Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0815 Kevin L. Morris 13 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Peninsula Salis bur U Regional Medical WICOMILO 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 52 214-66-7987 10, 1954 Maryland **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director DE Sussex Delmar 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 19940 7 Emory Circle Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No 1973 -If Yes, Give Year or Dates: 1974 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ white 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Occupational Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Safety 12 Safety Inspector h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be t and 2 should be Health and Menta tem 27 is marked Shirley Walker John Morris, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, DE 19956 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. 8737 Bacons Road Jacob D. Morris (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 17, 2007 Hebron, Maryland Memory Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home 13 E. Grove Street Delmar, DE 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high full results only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Ground level **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi Due to (or as a consequence of) ng physician as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9□1 Inknown ģ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 212 No HTW 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this Date of Injury
(Month, Day Year) 28d. Describe how injury occurred funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death or Attending 5 ☐Pending investigation Injury 1 Natural Fall grord level 1700 1 Yes 2 Accident 3 ☐ Suicide hours after death uneral Director: filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 7 Envery Circle nome Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Braminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H5049) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100E CARROLL St. SALISBURY Md. 21801

Registrar

Christopher Snyder

JUL 1 6 2007

31. Date filed (Month, Day, Year)

D.O.

32. Registrar's Signature

			For Amended 26,7/17/07, LDE Registrar	aryland / Depa , DOR Cer	artment of F	Death	Re 2. Date of Death		24502
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) Vesta Lucille Peddicord				July 8,	2007 Year	9:45 а м
	/Medic	al	4a. Facility Name (If not institution, give street and number,		4b. City, Town, o	or Location of Death		4c. County of Death	
	Examin	er	Mallard Bay Care Center			oridge			nester place (State or Foreign
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth		h Carolina
	Director		242-70-1696 Usual Residence of Decedent	//					404 India City Limite
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation			-	10d. Inside City Limits 1 ☐ Yes 2 No
	8-1-e	Director	Maryland Dorchester	Vienna	10f. Zip Code		11	0g. Citizen of What Co	untry?
2	with th		10e. Street and Number		21869	a		USA	
\$	within 72 hours after deeth with the Maryland ane. then "neturel", or iteme 23e or 28e-1 ehow he Wedical Examinar must be motified at	Funeral	2314 Elliott Island Rd. 11. Marital Status 12. Was Deceden	Ever in U.S. 13.		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
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9	urel', c	d by	3 XWidowed 4 □ Divorced Year or Dates	1 tCa Dana	ident's Usual Occu	nation	-	16b. Kind of Business/	
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	r Heal		20a. Method of Disposition	20b. Place of Disp		ace)	Date	20c. Location - City or	Town, State
Baltimore,	Page ent o nt: if ry or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Peddicor	d Cemete	- /		ienna, MD	
alti	permit. Pag Depertment Important: eny injury once.		21. Signature of Funeral Service Licensee	20110000	22. Name and Add Curran-E	ress of Facility Promwell 1	Funeral H	Home, P.A.	
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		ľ	shock, or heart failure. List only one cause on each	line.	0.000	- 0	a. A. O.	seose	Onset and Death
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Division of Vital Records,	r Atte ler de lrecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place 0 building	f Injury - At home, farm, , etc. <i>(Specify)</i>	street, factory, off	се	City or To	(Street and Number or wn, State)	Adrai Addie Nulliber.
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	Hosp 24 ho Fun etely f	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the base and manner	is of examination and/or	r investigation, in r	ny opinion, death of	courred at the time,	, date and place, and	
	To the Within To the	Z	29b. Signature and title of certifier		29c. Lic	ense number		29d. Date signed (Mo	onth, Day, Year)
			Mahter a MI)		3359		1/121	0/
_			30. Name and address of person who completed cause Mahbuba Akhter, MD, 607 Du	of death (Item 23a) (Type tehmon s. T.N.	pe, Print) J Factor	MD 2160)1		
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			Registrar			incate or		Date of Death	1	3. Time of Death
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	/Medic	at I	Edward Ernest	Post, Jr.		4h City Town o	r Location of Death		c. County of Death	13.33
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Ĕ	should Ind Men marke	ပ္	19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Stree	t and Number or Rural F	Route Number, Ci	ity or Town, State, Z	ip Code)
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused th	e death. Do not e	nter the mode of dy	ying, such as cardiac or i	espiratory arrest	,	Approximate Interval Between Onset and Death
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Vital		BeC	25. Was case referred to medical				26. Place of Death			
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Ö	Attending Ir death. ector: After	atio	2 ☐ Accident investiga	ition			☐ Yes 2☐No	Of Leasting (Circ	and Number or F	Rural Route Number,
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			_ For	State of Maryla				Mental Hy	giene			
			State Registrar		Cei	tificate of	Death		Reg. No. 🕜	1007	-01	501
40.	Physicia	an	Decedent's Name (First, Middle, Last					2. Date of De Month	eath Day	Year	3. Time of	4. 4
1	/Medic	al	NICHOLAS PAU			4h Cihi Town o	or Location of Death	JULY 1		07 unty of Death	B:10	P M
)	Examin	er	4a. Facility Name (If not Institution, give SOUTHERN MARY		ГТАТ.	CLINT				NCE G		219
	Funeral		5. Social Security Number 6. S	iex 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	th		place (State ontry)	
ш	Director		220-15-7699	X□M 2□F 25	Yrs.	Months Days	Hours Min.	SEPT.	21,1		IARYLA	
	put		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside C	ity Limits
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	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show wit, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.1	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or Noto Rican, etc.)	D- 14.	Race - Ameri Black, White,		
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8	atten atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	Fetal death 3	∃Ectopic pregnand ∃Other (s <i>pecify</i>) _	у		200	Month	-	Year
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Division or Vital Records, P.O. Box	The law requires that the death certifinate has been signed by the attending to page 2 should be detached for use as	y P	Part II. Other significant conditions of	•	_	nderlying cause gi	ven in Part I.	23e. Did		contribute to		/
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	ital or rs afte ral Dii led in	Cert		Demaning, tree (-)								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		(Check only 2 Medical Exam	hysician: To the best of my miner: On the basis of exar								(s)
	o the ithin 2 o the mplei	Medical	one) 29b. Signature and title of certifier.	and manner stated.		29c. Licen	se number		29d. Date s	signed (Month	, Day, Year)	
1	F≯Fö		1-500218			Dr	10324			4 13,		
("			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	,					
	NB 5		TERRY JODRIG	=, MD 750	3 SURRI	ATTS ROA	HD, CLIM	NOW, A	1 ARY LI	AND.	2073	5
	Sta Registr		31. Date filed (Month, Day, Year)	32. R gistrar's S	ignature	hede						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month CHARLES GRANGER PRUETT JULY 1, 2007 12:41 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL ELKTON, MD CECIL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1**☆**M 2□F Hours 219-66-0626 Director JULY 28, 1954 HAGERSTOWN, MD Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits iral', or items 23a or 28a-f ehov Examiner must be notified at Director 1 Yes 2 No MD CECIL ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 159 WINCHESTER DR. 21921 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 is marked other than other treumatic event, the Me. Elementary/Secondary (0-12) College (1-4or 5+) PHOTOGRAPHER **PHOTOGRAPHY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL PRUETT ဥ DODY LURA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY ANN PRUETT 159 WINCHESTER DR., ELKTON, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of H Important: If its eny injury or ot ance. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) NORTH EAST CEMETERY JULY 7, 2007 NORTH EAST, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SPICER-MULLIKIN 1000 N DUPONT PKY NEW CASTLE DE 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Physician Infarction /Medical Due to (or as a consequence of): Examiner Coronary I Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physicien and for use as the burial-transit Exami Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death signed by the aid be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Tillaknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No s certificate has the lirector, page 2 s 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 PER/Outpatient 3 DOA funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division 1 Natural 5 Pending Injury death. spital or Attendi nours effer death. neral Diractor: A investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 6 To the Funsral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyler stated. (Check only one) 29b. Signature affid title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00062687 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Hospital Efforms Andrew 4 97 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 28f. perME.g870, 8/16/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** IARY 0650 11/NS 2007 Jul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAIT, MORE UNIVERSITY OF MARY/AND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 1 F 217-06-8841 Director 9/3/1979 Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits MD Baltimore City 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 100 Harbour View Drive, Unit 414 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paramedic/Fire Fighter Emergency Rescue d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rodney L. Rollins Terry Petty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health e Rodney L. Rollins/Father 15805 Little Ferry Road, King George, VA permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 22485 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Bridge Bap.Cem. 7/24/2007 Colora, Maryland 21. Si tur of Funeral Service Licesses 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St.Delta, PA vart1. In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) TRAUMATIC **Physician** /Medical Due to (or as a consequence of) APPROVED BY MEDICAL EXAMINER **Examiner** Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 | Yes 2 No 3 | Probably 4 | Unknown Completed page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1世Yes 2□ No 2 ER/Outpatient 3 DOA P this funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 12 No 119/2007 FALL FROM KOOT 2 Accident 0240 filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1415 Key highway 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide BUILDING +Baltimore, MD 29a. Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU41735H13809 2007

Registrar

State

DHMH 17 Rev 1/2001

BATTIMORE, MI)

S. GREENE

3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DH

2

SuT

JUL 3 1 2007

ERICH

31. Date filed (Month, Day, Year)

			For State	State of Ma	aryland		artment rtificate			and Me				21507
			Registrar 1. Decedent's Name (First, Middle, La	st)		001	incate	, 01 L	Jean	<u>-</u>	2. Date of Dea	Reg. No.	001	3. Time of Death
	Physici		John A. Ritter,								Month July	15	2007	11:15 PM
)-	/Medio Examin		4a. Facility Name (If not institution, give				4b. City, T	own, or	Location of	of Death			inty of Death	
			88 Third Street				Ches	sape	ake C	ity			Cecil	
	Funeral		5. Social Security Number 6. S	Sex 7. Ag		ast birthday)	If Under 1 Months	Year Days	If Under :	Min.	8. Date of Birt (Month, Day	y, Year)	9. Birth	place (State or Foreign
	Director		220-30-5623 Usual Residence of Decedent	. W	73	Yrs.]	Dec. 8,	1933	Ma	ryland
	land ow		10a. State 10b. County		10c. City	r, Town or Lo	cation							10d. Inside City Limits
	Mary Fed	tor	Maryland Ce	cil		Chesai	peake	Cit	v					1 X Yes 2 □ No
	h the	Director	10e. Street and Number		1		10f. Zip (<i></i>			10g. Citizen	of What Cou	ntry?
	238 c	ai D	88 Third Street					219	15			US.	A	
	tems tems	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. \	Was Decede f Yes, speci	ent of His fy Cubar	spanic Ori	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	- 14.	Race - Americ Black, White,	
36	rs afte	by Fi	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates:		5.0	1□Yes 2	⊠ No	Specify:			Spi	ecify:	ita
8	thurs	edt	15. Decedent's E		1952-	16a. Deced	dent's Usual	Оссира	ation			16b. Kind o	of Business/In	ite
215	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Madical Examinar must be notified at	pie	(Specify only highest grade) Elementary/Secondary (0-12)	ade completed) College (1-4or 5	i+)	(Give	kind of work DO NOT use	k done d e retired)	luring mosi)	t of workin	g			
2	og en	Completed	12			Analy	yst						Compa	ny
<u>n</u>	d oth	Be	17. Father's Name (First, Middle, Last								(First, Middle,		пате)	
<u> </u>	nould Men narke	To	Maynard A. Ritte			401. 11. 11.	A 14	(2)			Foste		- 04-4- 7	- 0 - 1-1
Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show simportent: If item 27 is marked other than "naturel", or items 23s or 28s-f show simply or other traumatic event, the Medical Examinar must be notified at ODICE.		19a. Informant's Name/Relationship (Jean L. Ritter/W			PO PO	BOX 1	136.a	na Numbe	Cho.	Route Numbe Sapeake	Citrar	MD 2	1015
ē,	Heal Heal tem 2		20a. Method of Disposition	116	20b. PI	lace of Dispo					ate		on - City or To	
OE.	Pages ent of nt: if i		1 🕅 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia			iel Cer			1	7-19-	-2007 C	hesan	eake C	ity, MD
Baltimore, Maryland 21215-0036	partm partm ports r inju		21. Signature of Funeral Service Lice		P 0 0 1.	22	Name and	Addres	s of Facilit	·				
<u> </u>	Depa impo sny ii		In the	1		Ţ	318 Ge	roa	ra fu e Str	nera.	Chesap	eake	City, I	MD 21915
r			23a Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	i the death ne.	. Do not ent	er the mode	of phying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Canc	a c	ot /	teac	5/_	4 0	Ne	cK			Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):							1	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uence of):	_							
	sate be executed physicien and the burial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events	C										
Ö,	death certificate be executed e attending physicien and od for use as the burial-transit	Ex	resulting in death) Last	Due to (or as	a consequ	ience of):								
8760,	hysic the bu	dicai	•	d										
9 X	entific ding p	/Me	IF FEMALE:	23c. If yes, outcome	of program	201								
Вох	eath c attend	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3	Ectopic pre Other (spe					23d.	Date of deliv Month	ery Day Year
о. О.	that the death certificated by the attending placed by the attending placed for use as the	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	timo or de	Ja 5_	2 Othor (alpe	y/						
	The law requires that the tee has been signed by the bage 2 should be detache	by Pi	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying ca	use give	en in Part I.		23e. Did to	obacco use	contribute to t	he cause of death?
Vital Records,	w require been sig should b										101	res 2□N	o 3∏Prol	bably 4 Unknown
900	e iaw re has be ge 2 sho	Completed									24a. Was		4b. Were auto	opsy findings available ompletion of cause of
	The ate h page	Com									perfo	rmed?	death? 1 ☐ Yes	2100
/ita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
	Physi this o	2	1 ☐ Yes 2 ☐ Wo	Hospital: 1 Inpatie		ER/Outpatien			4 1 190	irsing Hom			Other (Special	(y)
CO	ding h. After funer	tion	1 ☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M Z	Bc. Injury Work	rai (? Yes 2∐I		8d. Describe h	low injury or	curred	
Division of	Attending Physicien: It death. Sector: After this certified by the funeral director, it	fica	3 Suicide 6 Could not b	28e. Place of Inj	ury - At ho	me, farm, str							umber or Run	al Route Number,
É	s after	Certification:	4 Homicide determined	building, et	c. (Specify	·)					City or Tox	vn, State)		
	Plospital or Attend 24 hours after death Funeral Director: etely filled in by the	edical (29a. Certifier 1 Certifying Pl	nysician: To the best miner: On the basis o	of my know	wledge, death	n occurred a	t the tim	ie, date an	d place, a	nd due to the	cause(s) and	manner as s	stated.
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: Atterthis certificate his completely filled in by the funeral director, page	Medi	one)	and manner st	ated.									1
	T with	_	29b. Signature and title of certifier			.17	290.	License	number	111	10	Zau. Date s	gned (Month,	67
,			2011	completed	looth (fr	230) 7	Pair	4	706	94	+ 1	61	16/	~/_
1	2+1VA		30. Name and address of person who	CAN A	M) /// V	Vest	-Hia	1,5	1-5	urto :	302	EIKT	on M1) 219
	Sta		31. Date filed (Month, Day, Year)	7/32. Registr	ar's Signat	ture	d	1	V . V . I		/ (

		State Registrar 1. Decedent's Name (First, Middle)	la lacti	State of		Ce	rtificate		eath		2. Date of	Reg. I	2.00	1	3. Time of Death
ician				r. RICH	ARDSON						Month	11	2007	/ear	10:43 PM
dical niner	20 4	la. Facility Name (If not institution	n, give st	reet and numb	ber)		4b. City, To	own, or L	_ocation o	f Death	001	-	4c. County of	Death	10.43
miei	l.	NATIONAL NAVA	AL MI	EDICAL	CENTER			BETI	HESDA	A			MONT	r Gom	ſERY
		5. Social Security Number 225-70-9417	6. Sex	м 2[Х F	Age (In yrs.	last birthday) Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	Min.	8. Date of (Month,	Day, Ye	ar)	Cour	place (State or Foreign ntry) ginia
	_	Usual Residence of Decedent 10a. State 10b. County	,		10c. Cit	y, Town or Lo	ocation							1	10d. Inside City Limits
ţ	5	Virginia Fair	rfax		Vi	enna									1 ☐ Yes 2 X No
Director	1	10e. Street and Number					10f. Zip C	Code				10g.	Citizen of Wh	at Cour	ntry?
ral	8	2414 Newton St.					2218					USA			1
Funeral	1	 Marital Status Never Married 2 Mar 		 Was Deced Armed Ford 1 ☐ Yes 2 	es?	.S. 13.	Was Deceder	nt of His y Cuban	panic Orig i, Mexican	gin? (Spe , Puerto	Rican, etc.)	No-		White,	can Indian, etc.
2	2	3 ₩ Widowed 4 Divorced		If Yes, Give Year or Dat			1 ☐ Yes 2 ∑	No No	Specity:				Specify:	Wh	nite
Completed	200	15. Deceder (Specify only highe	nt's Educ	ation		16a. Dece	dent's Usual	Occupat	tion urina most	of worki	na	16b	. Kind of Busi	iness/In	dustry
mple	2	Elementary/Secondary (0-12)	1	College (1-4	4or 5+)	life.	DO NOT use	retired)	3		3				
		17. Father's Name (First, Middle,	l ast)	2		Home	emaker		18 Mothe	r's Name	/First Mide		In Home		
o Be	ă	Ernest Ward Til		n					Jane				, , , , , , , , , , , , , , , , , , ,	,	
To	- -	19a. Informant's Name/Relations				19b. Maili	ing Address (nber, Ci	ty or Town, St	tate, Zip	Code)
		Virginia Richar	rdsor	n/Daugh	ter	2414	Newton	n St.	Vi	Lenna	a. Va.	221	181		
		20a. Method of Disposition			20b. F	lace of Dispo	osition (Name matory or oth	e of ner place,)	Ţ	Date	20c	. Location - C	ity or To	own, State
		1 XBurial 2 Cremation 4 Donation 5 Other (S		moval from Si	Nat	ional	Memori	ial l	Pk. 7	7/16,	/07	Fa]	lls Chu	ırch	, Va.
		21. Signature of Fundral Service	License	е		2:	2. Name and	Address	of Facility	у			171	L W.	Maple Ave
_	\top	23a, Part1, Enter the disease, o	r complic	ations that car	used the deat								nc. Vie	enna	Approximate
Jer		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teacing to immediate cause.	ar complicationly one	Due to (o	used the deat ch line. CORONAF r as a conseq	h. Do not en	ter the mode	of dying,	, such as				ic. Vie	enna	Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Anthony James Rizzo Ju₁y 10, 2007 pΜ 7:26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠**M 2□F Director 264-06-1418 54 Pennsylvania Aug. 11, 1952 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 11603 Dewey Road 20906 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Race · American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after an ent of Health and Mental Hygiene.

The filed T is marked other than "natural", or lieu my or other traumaite event, the Medical Examinea ury or other traumaite event, the Medical Examinea. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Anthony Rizzo Sr. Irene S. Whitesell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai once. Lana Rizzo / Wife 11603 Dewey Road, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory7/14/2007 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part*, rnte the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Brain Metastatic Tumor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tra Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown ğ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ▼ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy performed certificate 2 🙀 No 25. Was case referred to medical Be 26. Place of Death Check onl one Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo မှ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) furieral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Aftler 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours at er within 24 hours at To the Funeral D completely filled 29a. Certifier 1 🔀 Certify g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

death with

Saltimore, Maryland 21215-0036

The law requires that the death certificate be executed

the Hospital or Attending Physician:

To

Division or Vital Records, P.O. Box 68760.

30. Name and address of person, ho completed use of death (Item 23a) (Type, Print)

32 Registrar's Signature

Damirez T Fossett

JUL

17

31. Date filed (Month, Day, Year)

D50791

2101 Medical Park Drive, Silver Spring, Maryland 20902

July 10, 2007

			State of Maryland / Dep	partment of H e <i>rtificate of I</i>			giene _{Reg. No} 201	37	24510
	_		1. Decedent's Name (First, Middle, Last)			2. Date of De Month		Year	3. Time of Death
40.	Physici /Medio		Martha Ada Rhett Roberts			Ju1y	12, 20		4:40 PM
	Examir		4a Fecility Name (If not institution, give street and number)	4	4b. City, Town, or L	ocetion of Death	4c. County of	of Deeth	
			Sacred Heart Home		Hyattsvi]		Prince		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da	y, Year)		ace (State or Foreign ry)
	Director		578-24-7937 98 Yrs. Usuel Residence of Decedent			Jan. 9,	1909	Irmo,	, SC
	end *=		10a. State 10b. County 10c. City, Town or	Location				10	d. Inside City Limits
	Meny	ō	DC N/A Washi:	naton					1X Yes 2 □ No
	28a	Director	10e. Street end Number	10f. Zip Code			10g. Citizen of W	hat Count	ry?
	Se a	<u>-</u>	1213 Holly Street	201	012			U.S.	
	death	Funeral		B. Was Decedent of H		ecify Yes or No	14. Race	- America	an Indian,
020	urs after al', or ite	by Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2½ No	Specify:	nicari, etc.)		Bla	
altimore, Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Merylend Depertment of Heelth end Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show supf injury or other traumatic event, it a Medical Examiner must be notified at ance.	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usuel Occup ve kind of work done of DO NOT use retired	eation during most of work d)	sing	16b. Kind of Bu	siness/Ind	ustry
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and S	to be fill	Be	17. Father's Neme (First, Middle, Last)		18. Mother's Nam		Maiden Sumame	9)	
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1	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart feilure. List only one cause of each line.	inter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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Division of Vital Records,	raquir been s should	Completed					an autopsy rmed?	ava con	re autopsy findings ilable prior to npletion of cause leath?
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0 00	Attending Physician: or death. ector: After this cartific. by the funerel director,		27. Manner of Death 1	Wor	yat nk? Yes 2 □ No	28d. Describe	how injury occurre	ed	
DIVIS	2 # # E	Medical Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rural	Route Number,
	To the Hospital of within 24 hours at To the Funeral D Completally filled it	dical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de: 2 Medical Examiner: On the basis of examination end/or and manner stated.						
	Vithin Fo the	Me	29b. Signature and title of certifier	29c. Licens	e number		29d. Date signed	(Month, L	Day, Year)
	- 3-0		KTU O:	DI	1609		Ju1v 14	200	07
	5		30. Neme end edd ss of person who completed cause of death (Item 23e) (Typ	e, Print) DA	MAN	P. T.	111.1	411	0 -00
			10810 DARNESTOWN ROAD SO	e, Print) RA	2 GAITH	IGRSB	YRG M	102	0878
	Sta Registr		31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Cart o		70			

DHMH 16 Rev 6/95

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Physic		Milton	Roochnik				July 5,	, 2001	7 Year	11:20	a™
/Med Exami		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death	1	4c. Co	ounty of Death	J	
Exami	1101	Andrus House			Rockvi1	l1e		Mo	ntgomer	У	
Funeral	7.	Social Security Number 6.		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or	Foreign
Director		086-09-0198	18 M 2□F 92	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept 1	7, 19	14 New	York	
D .		Usual Residence of Decedent									
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8a-f	cto	-Montge		Bethesda	-					1 ,€3 ∜ es 2	2 140
ii th	Director	10e. Street and Number 165		it.	10f. Zip Code	02445	1	_	n of What Cour	ntry?	
Lat y latific Z. I.Z. 13-0030 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f ahow aumatic avant, the Medical Examiner must be nutified at	as a	10528 Farnham			- 200	514-		US			
e de	Funeral	11. Marital Slatus	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give		1 ☐ Yes 2 No	Specify:		Sp	pecify: Whi	te	
Pour Pour		15. Decedent's	Year or Dates: W		dent's Usual Occupa	otion		16h Kind	of Business/In	ducter	
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Hygi Hygi	ပိ	17. Father's Name (First, Middle, La.		0272	I Ingilio	18. Mother's Name	e (First, Middle,			1 400101	
d be antai	00	Shaya Roochnik				Shavna	Lefkow	ito			
mark mark	P	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a				own, State, Zin	Code)	
Mag dd 2 s lth ar trau		Mr. Paul Roochn			Farnham					,	
Head The		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date		tion - City or To	wn, Slate	
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paritimities, interpretation 2.12.13.0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinar must be nutitied at any injury or other traumatic avant, the Medical Examinar must be nutitied at any pince.		ZII SIGILAGIO CI I GIGAN SON AS ELO	The March						M1		250
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		shock, or heert failure. List on	ly one cause on each line.							Interval Betwee	een
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vical necolus, F.C. BOX 00/00, initian: The law requires that the death certificate be executed certificate has been signed by the ettending physicien and rector, page 2 should be deteched for use as the burial-transit	calE	Due to (or as a consequence of):									
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certii ding	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				230	d. Date of delive	erv	
etter i	clar	in the past 12 months?	1□Live birth 2 4□Pregnant at tir]Ectopic pregnancy] Other (specify)				Month		ear
che the c	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
that hed b		Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of de	ath?
uires d bi	d by	O Stevanthant	is				1 🗆 Y	es 2 21	No 3 ☐ Prot	ably 4 Dur	nknown
w requir been si should	Completed				n. 4.		24a. Was a	an 2	24b. Were auto	nev findings av	vailable
he la	Ę	Cerebourscul	27 1 37/1. 6. 2	weg was	VENENTO		autop		prior to co death?	mpletion of cau	use of
n: Til ficate or, pa		75 Was save referred to modical					1 ☐ Yes	-	1 🗌 Yes	2 No	
tending Physicien: The leath. for: Affer this certificate his funeral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	∆∏ 5D/0	oth	er:	1000		t o	Assis	sted
Phy Phy C	H	27. Manner of Death	28a. Date of Injury	2 ☐ ER/Outpatier 28b. Time o	IL 3 DOX	4 🗀 Nursing Ho	ome 5 Resid		 Other (Specii occurred	y I ivin	
Affe Affe	후	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day	Year) Injury	Work	k? Yes 2 □ No					
deal ctor; y the	flca	3 Suicide 6 □ Could not	be 290 Place of Injun	y - Al home, farm, sti			28f. Location (S	Street and N	Number or Rur	al Route Numb	er,
Per de la company de la compan	Certification:	4 Homicide determine	building, etc.	(Specify)	,,		City or Tow				
spite nours nerai		29a. Certifier 1 € Certifying	Physician: To the best of	my knowledge, deat	h occurred at the tim	ne, date and place.	and due to the d	cause(s) an	nd manner as s	tated.	
To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be deteched for use as the	edical	(Check only 2 Medical Ex	aminer: On the basis of e and manner state	xamination and/or in	vestigation, in my of	pinion, death occur	red at the time, o	date and pl	ace, and due t	o the cause(s)	
To th Mithin Fo th	₩ W	29b. Signature and title of certifier	2 -		29c. License	e number	2	29d. Date s	signed (Month,	Day, Year)	
- > - 0		Tobet 2000 9317 7/8/0							7		
9+1		30_Name and address of person wh	o completed cause of dea	ith (Item 23a) (Tyne	-	1311		/	01		
		Robert F. Byza		33 5 NA		NLINCTO	NVAZ	7202	_		
St	ate	31. Date filed (Month, Day, Year)	32 Registrar		100		1				
Regist		177	007 France	, the All	SALL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 Physician July 15, John Henry Reece 1514 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Havre de Grace Harford Harford Memorial Hospital 8. Date of Birth (Month, Day, Year) Sept. 29,1922 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1⊠M 2□F Yrs 183-16-3692 84 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryla 1⊠Yes 2 No Directo Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1592 Perryville Road 21903 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: If Yes, Give Year or Dates: 1942-46 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) V.A. Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Perry Point, Maryland Counselor/Psychology Unit Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental Jenifer Devlin George Reece ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mary Jo Reece (wife) 1592 Perryville Road, Perryville, Maryland 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State West Nottingham Cemetery 07/19/07 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign rure of Funeral Service Licer see 22. Name and Address of Facility WILL DON ST Lee A. Patterson & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Immediate Cause (Final Heart **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physicien and for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 💓 Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Uskes hours certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours effer or To the Funerel Direct completely filled in by 4 Homicide o the Hospitei or 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-15994 7-16-07 S. UNION AVE. HAURE DE GRAGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 741VA S. GALVEZ, M.D 625 31. Date filed (Month, Day, Year)

JUL 17 20 32. Registrar's Signature State 2007 Registrar

Certificate of Death

2. Date of Death

3. Time of Death

Baltimore, Maryland 21215-0036

	Decedent's Name (First, Middle	, Last)				Month		Year	3. Time of Death	
ician dical	VIRGINIA	RICHARDSON				JULY	11 2007		10:55A M	
niner	4a. Facility Name (If not institution	give street and number)		4b. City, Town, or	Location of Deat	h	4c. County c			
	7600 FOUNTAIN	E BLEU DRIVE # 3	04	NEW CA	RROLLTO	N	PRIN	CE GE	EORGE'S	
al	5. Social Security Number	6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthpl Count	ace (State or Foreign	
or	239-32-1108	1□M 2፟\(\text{F}\) 84	Yrs.	World Buyo	110010	FEB 14		IRGI		
	Usual Residence of Decedent								24 1-14-04-11-14	
	10a. State 10b. County	10c. City	y, Town or Lo	ocation					od. Inside City Limits 1 X Yes 2 □ No	
향	MD PRINCE	E GEORGE'S NEV	CARR	OLLTON						
once. To Be Completed by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W		try?	
=	7600 FOUNTAINE	E BLUE DR # 304		20784			U.S.A	7.		
Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race	- America		
T.	1 ☐ Never Married 2 ☐ Marri	ed 1 ☐ Yes 2 No		1 ☐ Yes 2 ☑ No		no mean, etc.)			BLACK	
þ	3₺Widowed 4□Divorced	If Yes, Give Year or Dates:		ILIYes 2124 No	Specify:		Specify:			
Completed	15. Decedent	's Education	16a. Dece	edent's Usual Occup	ation	orkina	16b. Kind of Bus	siness/Ind	lustry	
be	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	dining most of we	n King				
틍	7th	Conogo (1 101 01)		HOUSE KEE	PER		PRI <u>V</u> A	ATE		
Be C	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle,	fle, Maiden Surname)			
To B	WILLIAM ATKINS KATIE GARRISON									
15	19a. Informant's Name/Relations									
1 0	19a. Informant's Name/Relationship (Type. Print) MARIAN I. HARRIS/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 7600 FOUNTAINE BLEU DRIVE # 304 NEW CAR									
-	20a. Method of Disposition	City or To	wn, State							
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of cemetery, crematory or other place) 20c. Location - City of cemetery, crematory or other place)									
	4 □ Donation 5 □ Other (Specify) RESURRECTION CEMETERY 7/17/07 CLINTON, MARYLAND									
9	21. Signature of Funeral Service Licensee/ 22. Name and Address of Facility J. B. JENKINS FUNERAL TO A LANDOVER, MARYLAND									
4	X.D.19	-hall						TAIND	20785	
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the deat only one cause on each line.	h. Do not er	nter the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. METASTATIC PANCREATIC CARCINOMA									
	resulting in death)	Due to (or as a consec								
	0	b								
je je	it any, tracing to in receiving	Due to or as a conse	uence of):							
Ē	Sequentially list conditions, it seems to be cause. Enter Underlying Cause (Disease or injury that initiated events	C			_					
Examiner	resulting in death) Last	Due to (or as a consec	quence of):							
		d								
cian/Medical										
1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn	ancy				23d. Dat	e of delive	ery	
<u>S</u> .	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of		☐ Ectopic pregnanc ☐ Other (specify) _	y 		Mo	nth	Day Year	
Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown								
유	Part II. Other significant condition	ons contributing to death but not res	sulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco use cont	ribute to tl	he cause of death?	
b						1 🗆	Yes 2□ No	3 ☐ Prob	oably 4 🔀 Unknown	
teo						-				
lple						24a. Was	psy	prior to co	opsy findings available impletion of cause of	
Completed						1 Yes	rmed?	death? 1 ∐ Yes	25 No	
l as	25. Was case referred to medical 26. Place of Death Check onlone									
10 B	examiner? 1 Tyes 2 No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatie	ent 3□ DOA Oth	ner: 4 Nursing	Home 5 Res	idence 6 □Oth	er (Speci	fy)	
	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury		ry at rk?	28d. Describe	how injury occur	red		
fication:	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	ig .	gary		Yes 2 □No					
Į <u>š</u>	3 ☐ Suicide 6 ☐ Could		ome, farm, s	street, factory, office			Street and Numb	er or Run	al Route Number,	

Division or Vital Records, P.O. Box 68760, and Number or Rural Route Number, To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by Certi 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific JULY 13, 2007 D32261 ompleted cause of death (Item 23a) (Type, Print) 9500 ANNAPOLIS ROAD #A-4 LANHAM, MARYLAND RICHARD FELDMAN M.D. 31. Date filed (Month, 32. Registrar's Signatur State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24514 State of Maryland / Department of Health and Mental Hygiene [State Registrar Amend 5.7.&8.PenTHPC7-18-07cm Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 14, **Physician** 2007 6:46 Rockwell Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Sligo Creek Nursing Home Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9-10-1916 9. Birthplace (State or Foreign Country) White-Oak, Maryland Funeral 1 □ M 2 □ X = 90 94 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Mcdical Examinar roust be notified at 1 Yes 2 □ No Director MD Prince George's Hyattsville death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 6700 Belcrest Road # 1002 20782 United States or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after ☐Yes 2. No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 XWidowed 4 □ Divorced Year or Dates natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) other than " Elementary/Secondary (0-12) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked out Be William Matter Carrie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8123 Burkart Court Greenbelt, MD 20770 Raymond Rockwell (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o important: If eny injury or once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Fort Lincoln Cemetery 7/20/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Brentwood, MD 20722 Road Muhars how 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Cebrovascular Accident /Medical Due to (or as a consequence of) Examiner Systemic Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day jo Month Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2√ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy rmeg./ 2. No 1 Yes 2□ No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 2 **X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

12

3415 Hamilton street Suite #1

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven T. Tee, MD

31. Date filed (Month, Day, Year)

D 46998

7/16/2007

Hyattsville, MD 20782

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend#1.PerPhys.PCC7-16-07cr Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month JOSEPH KWESI RHULE 17:10 PM **Physician** 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner maryland Medical y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Min. 4-16-45 Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) SIERKA FREETOWN, LEONE 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Yrs. 62 579-76-9840 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show at M∑Yes 2 □ No MD PRINCE GEORGE BELTSVILLE an "natural", or items 23a or 28a-f sh Medical Examiner must be notified Director death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11814 ELLINGTON DRIVE 20705 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No AFRICAN AMERICAN Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5+ YRS. Elementary/Secondary (0-12) CIVIL ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GLANDYS THOMAS JOSIAH D. RHULE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11814 ELLINGTON DR. BELTSVILLE, MD 20705 YVONNE W. RHULE (THOMAS) WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 Removal from State GEO. WASH. CEMETERY ADELPHI, MD 7-21-07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 21. Signature of Funeral Service Licensee WASH., DC 20002-5236 524 - 8TH ST., Ε. N. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Escoha gea /Medical Due to (or as a cons suience of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760. Physician/Medical if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an the funeral director, page 2 s autopsy performed? 1☑ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Yes Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide

within 24 hours a

To the Funeral [

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 1 8 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene

WD

Baltimor

Two certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

2001

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		1	For State Registrar	Otale of ivi	iai y iai i		rtificate c				Reg. No.	1007	245 6
			Decedent's Name (First, Middle,	Last)						2. Date of Dea	ith		3. Time of Death
	Physicia		Isabelle	S.		Roge	ers			July 13	3 . 2	907 Year	12:30P. M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town	n, or Locetion	of Death		4c.	County of Death	1
			Lorien of Mt. Ai				Mt. A		-0411			Carroll	
	Funeral		,	5. Sex 7. A 1 ☐ M 2 ☐ F		last birthday) Yrs.	If Under 1 Ye Months Da			8. Date of Birtl (Month, Day	v, Year)	Co	nplace (State or Foreign untry)
	Director		212-32-1078 Usual Residence of Decedent		89)			<u> </u>	Aug. 1	8,19	I/ Mar	yland
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	a-f st	ctor	Maryland Freder	rick		Mt. Ai	Lry						1XXYes 2 □ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Cod	le			10g. Citi	zen of What Co	untry?
	ath w	rai	908 Winding Way		. C	0 10		21771	Naining (Can	aifu Van as Na		USA 14. Race - Ame	ocan Indian
	ltems rerr	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceden Armed Forces 1 Tyes 2	?	.S. 13.	Was Decedent If Yes, specify (Cuban, Mexic	an, Puerto f	Rican, etc.)		Black, White	
36	irs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 21⁄2	No Specif	y:			Specify:	White
0-10	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modical Examit er must be notified at	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Oc	cupation	ost of workir	na	16b. Ki	ind of Business/	Industry
21	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use re	tired)					
21	filed w Hygier other th		17. Father's Name (First, Middle, L.	2		Data	Proces		hor's Namo	(First, Middle,		Govern	ment
and	I be fi	Be						10.14104		abeth	17,010011	Nelso	n
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avant. I'm Modical Examiner matter notified at	2	Joseph M. Stre			19b. Mail	ing Address (Str	reet and Num			r, City o	r Town, State, 2	
	nd 2 s ulth ar 27 is r trau		Margaret Neff/Da			908	Winding	g Way,	Mt. A	Airy, M	D 21	771	
re,	s 1 and 2 of Health itam 27 i		20a. Method of Disposition		20b. F	Place of Disp	osition (Name o	f place)	D	ate	20c. Lo	ocation - City or	Town, State
E	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.	3 ∐Removal from State ecify)			Cremat		7/16/	2007	Free	derick,	MD
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service L	icensee		2	2. Name and A	ddress of Fac	St	auffer	Fun	MD ^a 21 ^H 9	pe, PA
_	2011		D.J. ten	lan			<u>_</u>					MD 21//	Approximate
			23a. Part1. Enter the disease, or dishock, or heart failure. List of	complications that cause only one cause on each	ed the deat line.	th. Do not en	iter the mode of	dying, such a	as cardiac o	r respiratory at	rrest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. End S	tage	Vascul	ar Deme	ntia					Yrs.
	/Medical Examiner		, south a second	Due to (or a Aphas:		(uence of):							Yrs.
k		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or a		tuenes of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Chron	ic Re	nal In	suffici	ency					Yrs.
o,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or a								1	Yrs.
3760,	ate be hysici the bu	licai	,	d. Hyper	censi								115.
x 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcom	e of oregon	ancv						23d. Date of del	livon
Вох	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	al death 3	□Ectopic pregn □ Other (specif					Month	Day Year
o.	at the de by the	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown									
<u>α</u>	that ned b deta	by Pt	Part II. Other significant condition	ns contributing to death	but not res	sulting in the	underlying caus	e given in Pai	rt I.				the cause of death?
rds	w requires been sign should be	ed b	Atrial Fibrilla	tion, Neop	hasm	of Lip	, Cache	xia,		1 🗆 '	Yes 2	□No 3□P	robably 4 XUnknown
Records,	law re as bee 2 sho	Completed	Cerebral Vascul	ar Acciden	ts, A	nemia,	Osteoa	rthrit	is,	24a. Was		prior to	utopsy findings available completion of cause of
Ä		mo:	Immobility Synd	lrome, Fail	ure t	o Thri	.ve			perfo	rmed? 2 X No	death?	2 □ No
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	Haarital					ace of Death	(Check only o	one)		
of \	Physician: this certific ral director,	은	1 ☐ Yes 2 🛣 No 27. Manner of Death			ER/Outpatie	ent 3 DOA			me 5 🗆 Resi		6 ☐Other (Spe	scify)
	Jing After fune	tion	1 XNatural 5 ☐ Pending		Day Year)	Injury	м	Injury at Work? 1 Yes 2				,,	
Division	or Attanding after death. Diractor: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of I	Injury - At h	nome, farm, s	treet, factory, of	fice					ural Route Number,
<u>S</u>	alor/ after Dira	Certification:	4 Homicide	building,	etc. (Speci	ity)			ī	City or To	WII, State	9)	
	To tha Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by		29a. Certifier 1 Certifying	Physician: To the best Examiner: On the basis	st of my kn	owledge, dea	ath occurred at the	he time, date	and place,	and due to the	cause(s) and manner as	s stated. e to the cause(s)
	To the He within 24 To the Fe completel	ledical	one)	and manner		whom and/or						ite signed (Moni	
	To t	Σ	29b. Signature and title of certifier	Par	00.	1 M		cense numbe 54749	31			y 14, 20	
•			rucker	1/00	1	<u>/</u>							
1	O		30. Name and address of person v					'rederi	ick. M	D 21701	l		
	St	ate	31. Date filed (Month, Day, Year)	20 P ogis	strar's Sign	aturo							
	Regist		JUL 17	2007	we .	B A	code						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2235 PM **Physician** 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City he Johns Hopkins Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Social Security Number Hours Min. 1 □ M 2 🗓 F NOV 1951 North Carolina 11, 217-62-3775 55 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21921 United States 3145 Old Elk Neck Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: ò White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Educational College (1-4or 5+) Elementary/Secondary (0-12) Institution Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lessie J. Eller Raymond Benjamin Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 129 Bill Leight Road, Conowingo, Maryland 21918 Samuel A. Peterson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & July 27, 20c. Location - City or Town, State 20a. Method of Disposition West Chester, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 2007 Inc. 22. Name and Address of Facility Co., 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton Maryland 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sephic shock Due to lor as a consequence of): 5 hours **Physician** /Medical stage liver disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner non-alcoholic steatohepatitis Exami Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown 5 Other (specify) 4☐Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**X** No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopo performeo 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3□ DOA 2□00 2 ER/Outpatient 1 🗌 Yes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Manner of Death (Month, Day Year) Injury

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a detached f certificate has been signed by rector, page 2 should be detacl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Funeral

Director

d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygene.
7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

permit, Pages 1 and 2: Department of Health ar Important; If Item 27 is any Injury or other trau

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

23,2007

State Registrar

Medical

Kendall Moseley 31. Date filed (Month, Day, JUL 3 1

30. Name and address of person who

29b. Signature and title of certifier

Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

Fo the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2451 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) July 2^{Day} 2007 1600 Рм Paul Richard Schneiders 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Union Hospital E1kton if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) NOV 25, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1∭M 2□F 1946 222-30-1009 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Ceci1 North East Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code United States 906 Elk River Manor Drive 21901 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Reeder Clarence Schneiders

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

July 25,

21901

20c. Location - City or Town, State West Chester,

Pennsylvania

MD, 21921

906 Elk River Manor Dr., North East, MD

2007

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral

Director

the Maryland

/Medical

10a State

10

20a. Method of Disposition

KLEHEN14

31. Date filed (Month, Day, Year)

JUL 3 1 2007

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

Paul R. Schneiders/Self

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

Director

δ

Completed

Be

Pnysician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate hes been signed by the funeral director. After this certificate hes been signed by the funeral director.

į,	21. Signature of Funeral Service License	***		and Address of Facility S Home for Fur L. Stockton St			1ond 21021
	23a. Part . Enter the disease, or complishock, or heart failure. List only on	cations that caused the deathe cause on each line.				on, mary	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	Myocon	diel in	terction			Onset and Death
	resulting in death)	Due to (a conseq		ers dise			
_	Sequentially list conditions,	comon.		ery dise	DIE		
mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq		J			
cal Exa	resulting in death) Last	Due to (or as a conseq	uence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 Ectopic	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
ed by Ph	Part II. Dther significant conditions con	ntributing to death but not res	ulting in the underlyin	g cause given in Part I.		o use contribute	o the cause of death? Probably 4 Thinknown
complet					24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of s 2 \sum No
Bec	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
To E	1 ☐ Yes 2 No	lospital: 1 🗆 Inpatient 🛮 2	ER/Outpatient 3□	DOA Cther: 4 Nursing	Home 5 🗆 Residence	6 □Other (Sp	ecify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fac y)	tory, office	28f. Location (Stree City or Town, St	and Number or F ate)	Rural Route Number,
Medical Certification:	29a. Certifier 12 Certifying Physics (Check only one) 2 Medical Examin	eniant To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death occur ation and/or investigat	led at the time, date and star ion, in my opinion, death occ	te, and due to the cause curred at the time, date	e(s) and manner a and place, and du	e to the cause(s)
M	29b. Signature and title of certifier	,,,,		29c. License number	29d.	Date signed (Mor	ith, Day, Year)
	fellerine	- morror A	w	0006254	7	07-	24-07

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris & Co., Inc.

DHMH 17 Rev 1/2001

State

Registrar

sheet

Elicton

106

32 Registrar's Signature

30. Name and address of pa son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0720 am DUNENMARK KENNETH 13, 2007 KURT JULY 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) BROOKE GROVE REHABILITATION AND NURSING CENTER SANOY SPRING MUNTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Months Days 1⊠ M 2□ F Vre AUSTŔIA DEC 9, 1909 103-12-2983 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY MARYLAND OLNEY 1 N Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17439 CHEROKEE LANE 20832 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Affred Foldes: 1⊠ Yes 2□ No If Yes, Give Year or Dates: 1941–45 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALES MANAGER PAINT BRUSHES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JULIUS SONNENMARK IDA STRAUSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDIE BLITZSTEIN/DAUGHTER 17439 CHEROKEE LANE, OLNEY, MARYLAND 20832 JULY 15 2007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GARDENS OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DHE WEEK & BACTERIAL PUEUMONIA Due to (or as a consequence of): Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No DEMENTA SENILE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No

ed by the ettending physician and deteched for use es the buriel-transit certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

Examiner

/Medical

Physician

/Medical

Examiner

Director

Funeral

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Certification:

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4 Homicide

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylat Department of Health and Mental Hygiens. If them 23 and 28s-1 show Important: If item 27 is marked other than "natural", or Items 23a or 28s-1 show any Injury or other traumatic event, Ite Medical Examinate must be notified as

3altimore, Maryland 21215-0020

or Attending Physician: s efter death.

To the Hospital o within 24 hours of To the Funerel D completely filled in

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier MYLLO ATTENDING PHYSICIAN

12046

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACE BROOKETH FFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND

State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signature

			State of Ma - State Registrar Amend 28c, perME, 9870, 8/16		rtment of Health and I tificate of Death		ene2007	24520
1	n - a e	er i	1. Decedent's Name (First, Middle, Last)	707 11		2. Date of Death Month		3. Time of Death
	Physicia /Medic		Amelia Erica SHALLER			JUly 12	, 2007	7:25 P. M
	Examin	- 1	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospi	tal	4b. City, Town, or Location of Death Rockville		4c. County of Death Montgome	ry
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 TF	e (In yrs. last birthday) 20 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sept. 4, 1	Yea <i>r) C</i> o.	nplace (State or Foreign untry) ington, DC
	D		Usual Residence of Decedent	10c. City, Town or Loc	cation			10d. Inside City Limits
	farylar show ed at	ō	10a. State 10b. County Montgomery	Potomac	odioi i			1 ☐ Yes 2 ZNo
	with the N a or 28a-1 be notifi	Direct	10e. Street and Number 11733 Devilwood Drive		10f. Zip Code 20854	10	g. Citizen of What Co	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ★ Never Married 2 ★ Married 1 ★ Armed Forces? 1 ★ Yes 2 ★ If Yes, Give Year or Dates:	4o	│ Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer t ☐ Yes 2∰No Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
8	2 hour atural cal Ex	ted !	15 Decedent's Education	16a. Deced	dent's Usual Occupation	rkina I	6b. Kind of Business/	Industry
215	ithin 7 ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	+) life. L	kind of work done during most of wo. DO NOT use retired) Clerk	Many	Retail	
Maryland 21215-0036	be filed w ntal Hygier ed other the	Be	17. Father's Name (First, Middle, Last) Elliot Howard Shaller		18. Mother's Nar Wendy	ne (First, Middle, M Gerzog	laiden Surname)	
<u> </u>	should nd Mei marke imatic	မ	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or R			Zip Code)
Σ S	and 2 seath ar		Dr. Ellen Werner , stepmot!		B Devilwood Dr.,			
Baltimore,	ges 1 are tof He If Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	natory or other place)		20c. Location - City or	
Ħ H	it. Pag intment intant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Remembrance July 2. Name and Address of Facility	Torchins	v Nebrew	Tuneral Home
Ba	Depa Impo any I		Detry Dero	2.5	54 Carroll St., N	W, Washin	gton, DC	20012
	Physician		23a. Part1. Enter the sease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition a Card:	the death. Do not ent ne. io Pulmona:				Approximate Interval Between Onset and Death
	/Medical Examiner			a consequence of): ic Brain In	njury		OME	6 days
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Inflicted	Hanging \	1 July	, , ,	6 days
,0928	cate be executed physician and s the burial-transit	al Examiner	that initiated events resulting in death) Last C. Due to (or as Depr	a consequence of):	100%	0/11/0	7	years
687	ficate physis the	edical	d		100	71101		
.O. Box	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ปnknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
Δ.	w requires that the stand of the standard by should be detacted.	by Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause given in Part I.		es 2 X No 3 □ P	o the cause of death?
COL	w requ	Completed				24a. Was a	n 24b. Were a	utopsy findings available
Be	The lav	ошо				autops perform	y prior to ned? death? 2☐No 1☐Yes	completion of cause of 2 □ No
ita	(0 -	Be C	25. Was case referred to medical examiner?			eath (Check only on	e)	
2 \	Physician: r this certific ral director,	은		ent 2 ER/Outpatier			ence 6 Other (Special of the Control	ecify)
ono	Attending I r death. ector: After by the funer	tion	1 □ Natural 5 □ Pending (Month, Date 2 □ Accident investigation (7 / 06 /	y Year) Injury	Work? M 1 □ Yes 2 ▼No	1	ng ~ 5 <td>oflicted</td>	oflicted
Division or Vital Records,		Certification:	3 Suicide 6 Could not be 28e. Place of inj	jury At home farm, str. (Specify)	reet, factory, office	28f. Location (St City or Town	reet and Number or Fi n. State)	ural Route Num 20 850 r.Potomac,MD
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier (Check only (Ch	of my knowledge, deat of examination and/or in	th occurred at the time, date and place	ce, and due to the c	ause(s) and manner a	s stated.
	To the H within 24 To the F complete	Medical	one) and manner st 29b. Signature and title of certifier		29c. License number		9d. Date signed (Mon	
\	Z × Z S		> Clexander Mula	imila	0065819	l l	07/12/07	
•	5		30. Name and address of person who completed cause of c	de eth (lasen ODs) (Temp				
PÇ.	St	ate	·	rar's Signature	P		,	
	Regist	rar	I III I 7 ZUUT MEER	12 1 16 B	560 F			

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Rockville

3. Time of Death

7:20p

State or Foreign

7/13/2007

8 Date of Birth

4c. County of Death

Montgomery

29d. Date signed (Month, Day, Year)

D7-13-2007

Physician /Medical Examiner

Funeral

Sylvia S. Shere

Shady Grove Hospital

4a. Facility Name (If not institution, give street and number)

determined

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 17 2007

29a. Certifier

Director death with the Maryland show r 28a-f show notified at r than "natural", or Items 23a or the Medical Examiner must be Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Ite ury or other traumatic event, the Medical Examine. permit. Pages 1 and Department of Health Important; If item 27 any injury or other tr. once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

physician this After t death. after death Director:

or Attending Physician: The law requires that the death certificate be executed 24 hours a within 2 0

Division or Vital Records, P.O. Box 68760.

Age (In yrs. last birthday) 3/7/1919 9ear) Days Hours Country) Months 88 1 ☐ M 2 🔀 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1

▼IYes 2 No Md. Montgomery Germantown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21000 Father Hurley Blvd. Apt. 418 20874 US Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No þ, 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Administrative Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frieda Katz Adolph Sprotzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gaithersburg, Md. 20878 16004 Charles Hill Drive Fredda Valenti/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/16/07 Rockville, Md. Parklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of facility neral Direction 1091 Rockville Pike Rockville, Md. 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as consequence of): disease or condition resulting in death) aortic stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month 5 Other (specify) 4☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pertorm 1 ☐ Yes 2 No 26. Place of Death (Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

State Registrar

Medical

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rockville, Md. 20850 Dr. Aaron Snyder 9909 Medical Center Dr. Rockville, Md. 20850

32 Registrar's Signature

1 . Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

		•	For State Registrar	State of Ma	ıryland			of Healt of Dea		1	Reg. No	007	245	22
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of D	eath
	Physicia /Medic		Craig Woodle	v Sma	ck, S	r.				July	13	2007	18:05	М
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or Locat	ion of Death		4c. C	ounty of Death		
			9745 Peach Lane				If Under 1	Berlin	nder 24 Hrs.	0.0		Worcest	er place (State or I	Camien
	Funeral		5. Social Security Number 6. Se	X YM 2□F	i (In yrs. Ia 51	st birthday) Yrs.		Days Hou		8. Date of Bird (Month, Da March	7 8 1 9	56 Salis	bury, M	Foreign [D
	Director		219-62-8234 Usual Residence of Decedent		01					March .	20, 10	oo bans	Duly, 14	
	land		10a. State 10b. County		10c. City,	Town or Lo	cation						0d. Inside City	Limits
,	Mary	to	Maryland Worceste	r	Ber	lin							1 ☐ Yes 2	2 ∑ No
	death with the Maryland ma 23a or 28a-f ehow r must be notified at	rec	10e. Street and Number				10f. Zip 0	Code			10g. Citize	n of What Cou	ntry?	
	38 o	O IE	9745 Peach Lane					21811				USA		
		Funeral Directo	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	3. 13.	Vas Decede	ent of Hispani	c Origin? (Sp	ecify Yes or No Rican, etc.)	- 14	Race - Ameri Black, White,		
۰	hours after tural', or ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X N If Yes, Give	lo		1 ☐ Yes 2		ecify:	,		pecify:		
3	"natural",	d by	3 Widowed 4 Divorced	Year or Dates:							101 16:	Blac		
		Completed	15. Decedent's Ed (Specify only highest grad	de completed)		16a. Deced (Give	ient's Usual kind of work DO NOT use	Occupation done during retired)	most of work	ang	165. Kind	of Business/Ir	dustry	
7	within 72 ene. then "na he Medic	g E	Elementary/Secondary (0-12)	College (1-4or 5	+)	labor		, , , , , ,			Dona	way Fu	rniture	Co.
	Hygir Hygir Int.		17. Father's Name (First, Middle, Last)			Tabol	CI	18. N	Nother's Nam	e (First, Middle,			1111111	
<u>a</u>	d be ental ked c	To Be	Clavton			Purnel	1		Anna			Sma	ack	
Maryland	should nd Men marke umatic	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address ((Street and N	umber or Rur	al Route Numb	er, City or	Town, State, Zij	Code)	
	27 Le		Pamela O. Smack/s	oouse		9745	Peach	Lane	- Berli	n. MD	21811			
ē,	s 1 al		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name	e of her place)		Date	20c. Loca	ation - City or T	own, State	
Ĕ	Pages ment of ant: If It ury or o	1	1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		St.	Paul	UMC	Cem.	07/19	/2007	Berlin	. Maryl	and	
Baltimore,	aria orta		21. Signature of Funeral Service Licen	A 1 00	7					13 Jerse				MD
10	Deperment of the control of the cont		Patricia	(Jole	ey					CHAPE	-		218	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each lir	the death	. Do not ent	ter the mode	of dying, suc	h as cardiac	or respiratory a	rrest,		Approximate Interval Betw Onset and De	reen
	Physician		Immediate Cause (Final disease or condition	a	-	arole	ac	ar	1 by/	Enia	<u>.</u>		30%	ered
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):	2	50	/-				. 1	
	Lammer	-	Sequentially list conditions,	a cons	741	Dell	over	lec			- 1	SIR.	5.	
	ted nsit	ulu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ns uence of:									
	ie be executed rsicien and e burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequ	ence of):								
760,		cal		d										
89	Attending Physician: The law requires thet the death certificat rideath. •ctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	Medi	IF FEMALE:								- 1			
. Box	thet the death cer ed by the attendin detached for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			□Ectopic pre	gnancy			23	d. Date of delin	•	ear
H	e dea the at	200	1 \(\text{Yes} \) 2 \(\text{No}\) No 9 \(\text{Unknown} \)	4 Pregnant at 9 Unknown	time of de	eath 5[Other (spe	ecity)					,	
0.	d by letach		Part II. Other significant conditions of	patributing to death b	ut not resu	ulting in the u	ınderkina ca	use awen in	Part I	23e. Did	tobacco us	e contribute to	the cause of de	eath?
Š,	w requires thei been signed I should be det	ğ	Characio	P. 0	40	20:		3.70.1 m		10	Yes 2□	lNo 3 □ Pro	bably 4 🗹	nknown
Records,	requ	Completed	- Chronic	P 4	1	7				040 145		745 14/222 214	san findings o	v adable
ခ္	has t	dr	Oran	, arly	y Q	1130	se_			24a. Was		prior to o death?	opsy findings a ompletion of ca	use of
<u>=</u>	i: Th									1 ☐ Yes	3/1 No	1 Tes	2 € No	
Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other		th (Check only		COther (See	.4.)	
ō	Phys raldi	5.	1 Yes 2 No	1 ☐ Inpatie		P/Outpatie 28b. Time of		7	☐ Nursing H	ome 5 ☐ Res 28d. Describe			iry)	
Division of	ding th: After funer	ţ.	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м	8c. Injury at Work? 1 ☐ Yes	2 🗆 No					
/ISI	Atten deal octor	flca	3 Suicide 6 Could not be	28e. Place of Inj			reet, factory	, office			(Street and	Number or Ru	ral Route Numb	 Э⊖ <i>г</i> ,
5	al or a after	Certification:	4 Homicide	building, et	c. (Specify	′)				City di To	iwii, State)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Ph	ysician: To the best niner: On the basis o	of my know	wledge, dear	th occurred a	at the time, da	ate and place	, and due to the	cause(s) a	and manner as	stated. to the cause(s)	
	the H in 24 the F iplete	Medical	one)	and manner st										
	To Too	2	29b. Signature and title of certifier	0 /	7/	,	290	License nun	noer .	,	esa. Date	signed (Month	, Day, rear)	
)	MI		Donto	3.(hai	DAY		0-	1005	0		1116	1014	
0	- Mar	1	30. Name and address of person who	completed cause of c	death (Item	23a) (Type	Print)	0:	1	at c	> X	301 -	201	40-
-	٦		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	137	00	· 47/1	1131a	SF. S	uro.	30/	ious.	100
	Sta Regist	ate rar			a. o oigila		W 63							1
DH	MH 17 Rev 1/2		JUL 17	2007	-	B A	met !	-			177			1
						ORIG	iINAL							

7013, 18:05

DOB: 3128/54 DOD: 7/13/07

Smack Sr., Craig W. 219-62-8234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 20 E e. ERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTER PRUSBURY KEGIONAL MEDICAL WIRSMICO KENINSULA If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 0 M 2 □ F Days Min Yrs. Director 21-6 LAWARE Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No SDORG **Funeral Directo** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 'natural", or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: BLAC! 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th GRAZE Pages 1 and 2 should be filed vent of Health and Mental Hygirint: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HORACE HARMON

19a. Informant's Name/Relationship (Type. Print) MARMOA CE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any Injury or other trauonce. 124 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Nemoval from State 5 Other (Specify) 4 □ Denation Signature of Fineral Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) multishe injuries Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 🗌 Yes 4 Unknown certificate has been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2□ No 1∐ Yes 2 1 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 □ es 2 □ No in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 MER/Outpatient 3 □ DOA 1 Inpatient 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☐ Natural 2 ☐ Accident 5 ☐ Pending investigation Ran off road 9/2007 after death. 1245 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide DE Milshoro Roadwan R+ 113 within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only one) xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) (0) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Salis Duku

MO

21801

CARRUL

32. Registrar's Signature

Dryder

31. Date filed (Month, Day, Year)

07-05278 Ronald Stoltz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No.				
Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	ne of Death			
Medical Examiner Ronald Kenneth Stoltz July 9, 2007	338 hrs			
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Beach Rd @ Rt. 2 Dunkirk Anne Arundel				
Chicagodina Bedan No (Chicagodina Chicagodina Chicagod	o (State or			
Months Days Hours Min. Foreign W.	shington.			
217-76-3217 1AM 2 F 48 Yrs. 00714/1939 134377	DC			
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits			
	Yes 2 X No			
Maryland Calvert Owings Maryland Calvert Owings 10e. Street and Number 10g. Citizen of What Country?				
Maryland Calvert Owings Owings Control of What Country Owings Owin				
Maryland Calvert Owings Owings Collider Country Cou	dian Block			
4 9 1 1 X Never Married 2 Married Porces? In 1es, specify Cuban, Mexican, Foetio Rican, etc.)	idian, biack,			
1 Yes 2 X No specify: White				
To Divorced in Test 2 in T	TV			
during most of working life. DO NOT use retired)				
Photographer Verifier F.A.A.				
15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)				
Jack Richard Stoltz Naomi Jane Brockway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe				
To go and Jack Richard Stoltz Naomi Jane Brockway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	mber, City or Town, State, Zip Code)			
Naomi Jane McLane/ Mother 15 Butternut Road Riva, MD 21140				
Photographer Verifier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19. Maomi Jane Brockway 19. Informant's Name/Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe Name of Disposition 1	, State			
E a le le le la	VA			
Metropolitan Crematory 7/12/2007 Alexandria, 21. Signature of Finer Seguce Licensee 22. Name and Address of Facility Robert E. Evans Funeral 16000 Annapolis Road Bowie, MD 20715	Home			
16000 Amapolis Road Bowle, Fib 20715	1			
	proximate Interval			
Medical saminer Immediate Cause (Final disease a. Multiple Injuries	Death			
or condition resulting in death) Due to (or as a consequence of):				
Sequentially list conditions, b				
if any, leading to immediate Due to (or as a consequence of): Let cause. Enter Underlying Cause				
if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that immated events resulting in death) Last vents resulting in death) Last v				
dd.				
O a par of the first of the fir				
events resulting in death) Last d. UNPENDED AMENDED AMENDED IF FEMALE: 23d. Date of delivery 23d. Date of delivery Anoth Day Month Day				
Column Service Constitution of the past 12 months? 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Output (Specific)	Year			
So yet to the past 12 months? 2				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contributions contributio	ause of death?			
The state of the s	4 Unknown			
24a. Was an autopsy prior to comp				
autopsy prior to complete the first of the f	etion of cause of			
24a. Was an autopsy prior to comply death? 1 Ves 2 No	2 No			
TEXT SEE TO SEE				
24a. Was an autopsy performed? 1				
28a. Date of Injury 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 1638 hrs 1 Yes 2 No Driver auto/truck collision				
O B To B T	outo Number City			
O see at 1 page of injury				
determined (Specify) Major Road / Highway Chesapeake Beach Rd @ Rt. 2, Dunking Specify Chesapeake Beach Rd @ Rt	K, MD			
The past 12 months? 1	use(s)			
and manner stated. 29b. Signique and title of certifier 29c. License number 29d. Date signed (Month, I				
O.C.M.E. July 10, 2007	,			
(Carren)				
30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
Editif Looke Mid. Assistant Medical Examine: The Chiractest, Daltimore, Mid 21201				
State 31. Date filed (Month, Day, Year) Registrar 32. Refistrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 1140 FM Carolyn Margaret Small 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel 20 Unit K, Greystone Court Annapolis If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs last birthday) 5. Social Security Number Min. 09724/1946 Months Days Hours 1□M 2 F Washington D.C. 579-58-0688 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1¥ Yes 2 No Anne Arundel Annapolis Annapolis MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21403 20 Unit K, Greystone Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍎 No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Insurance Elementary/Secondary (0-12) Administrative Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Loraine Dalluge Nelson Henry Eugene Small 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 581 N. Sunnyslope, Pasadena, CA 91107 Diane Phelps/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 07/14/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ineral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erio disease or condition resulting in death) (or as a consequence of): Due to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 160 1□ Yes 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined

law requires that the death certificate be executed burial-tran and Division or Vital Records, P.O. Box 68760, attending physician the use as for the certificate has been Physician; After this

cate has been signed by t , page 2 should be detach funeral director, the filled in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show ns 23a or 28a-f shov must be notified at

or items 23a

th and Mental Hygiene. 7 is marked other than "natura"; or iten traumatic event, <u>the Medical Examiner</u> should be filed within 72 hours after and Mental Hygiene.

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permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

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Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

death with the Maryland

Hospital or Attending death. within 24 hours after death To the Funeral Director:

completely State

29b. Signature and title of certifier

7 2007

31. Date filed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

e of death (Item 23a) (Type, Print) 30. Name and address of person who completed

ONES

32. Registrar's Signatu

and manner stated

			1 - For State Registrar	State of Ma	arylan	•	artmen rtificat				lental F	Reg	ene . No:	17	24526	
	Physici	an	Decedent's Name (First, Middle, Las TIEDMANT								Month		Day	Year	3. Time of Death 4:38 A ^M	
- 6	/Medio		HERMAN D. TESSMAN							of Death	JUL	12	2007 4c. County	of Death	4:30 A	
	LAGITI		NATIONAL NAVAL ME	EDICAL CEN	TER			ETHES					MON	TGOM	ERY	
1- 10	Funeral Diréctor		4//-54-6893	ex 7. Ag	63	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of (Month, March	Day, Y	9. Bi 3, 1944 Min		irthplace (State or Foreign Country) nnesota	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limits	
	Many a-f sh	tor	Virginia Arlingto	n	Ar	lingto	n								1 ☐ Yes 2X No	
	or 28	Olre	10e. Street and Number	_			10f. Zip						. Citizen of			
	e 23e	ral	4731 North 11th S	12. Was Decedent	Everie II	6 12		205	onania Ori	igin? /Sn	andu Vac ar		nited		ean Indian,	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other than "natural", or Iteme 23s or 28s-f show any fujury or other traumatic event, the Madical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 A Yes 2 No			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 1 ☐ Yes 2X No Specify:					NO	Bla	ck, White,		
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Maryland	uld be file Mental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last) Herman D. Tessma				18. Mother's Name (First, Middle Iona Hahn					ldie, Ma	e, Maiden Sumame)			
lary	2 sho and N Is me		19a. Informant's Name/Relationship (Type, Print)			-						City or Town,			
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<u>α</u>	uires that signed by	Partin. Other significant continuous continuous to death out not resulting in the underlying cause given in Partin.									ne cause of death?					
Records,	Physician: The law require this certificate has been si al director, page 2 should b	Completed									a	Vas an utopsy erforme	d?	prior to co death?	psy findings available mpletion of cause of	
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Divisi	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 29a Place of Ini	ury - At ho c. (Specif	ome, farm, st	reet, factor					on (Stre Town,		ber or Rura	al Route Number,	
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	To the Ho within 24 I To the Fu completely	Ĕ	29b. Signature and title of certifier	DII	01		29	c. License	number				d. Date signe			
	20		1 pm	K Ha	u	-M.F	2	0101	2 4044	19 (V	7A)		JULY	12	2007	
	L		30. Name and address of person who			n 23a) (Type,	Print)						DICAL	CENT	ER	
1	Sta	ate.	JAMES R. HOLLIS 31. Date filed (Month, Day, Year)	32/Registr	USN ar's Signa	ature			BETHE	ESDA	MD 20	889	-5600			
*	Regist		JUL 1 7 20	107 Singer	U 1	K Go	and I									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JEFFREY JOEL TEICHMAN JULY 15, 2007 9:44A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1X M 2 ☐ F Yrs Director 214-96-2392 39 10/14/1967 NEW YORK Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Department of Health and Mental Hygiene. Information of Health and Natural and Informative if them 27 is marked other than "natural" or items 23a or 28a-f stany injury or other traumatic event, the Medical Examiner must be notified once. 1 Yes 2 No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1131 UNIVERSITY BLVD WEST 20902 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No WHITE Specify: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry
HANDICAPPED WORKSHOP 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CENTER 12 CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental I wit: If item 27 Is marked of MARTIN TEICHMAN 2 MARLA STERN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTIN TEICHMAN/FATHER 5 FULHAM COURT, SILVER SPRING, MARYLAND 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State BETH ISRAEL CEMETERY 07/16/2007 | WOODBRIDGE, NEW JERSEY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licenses 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician BILATERAL PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE RESPIRATORY DISTRESS SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death. PRADER-WILLI SYNDROME physician and the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical MORBID OBESITY IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. I 9□Unknown 9 Unknown certificate has been signed by ector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number BK 9 7 5 8 8 7 6 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pring Mb: 20910 Forest Glen Road KAPOOR Silvers 1500 RAMA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

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JUL

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Registrar's Signature

		1 - For State Registrar	State o	f Marylan			t of He			ental Hy	/giene Reg. No.	007	24528		
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permit. Pages 1 e Department of Hea Importent: If Itam eny Injury or othe		4 Donation 5 2 Other (Spe	cify)Donati	on An	atomy			į	7/7/			imore,			
mmit.	١.	21 Signature of Funeral Service Licensee 22 Name and Address of Facility HOLLOWAY Funeral Home Professional										sional A	ssociation		
1 40558		Javid A. Company CESP 501 Snow Hill Rd., Salisbury, MD 21804													
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Attending For death. Sector: After by the funera	atio	1 Matural 5 Pending 2 Accident investig	ation	, _u, /ou/	пдиту	М		Yes 2	□No						
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Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

To the Hospital or within 24 hours af To the Funeral D

Medical State

WM. D. BOYD, II 31. Date filed (Month, Day, Year) Registrar

29a. Certifier

one)

(Check only

29b. Signature and title of certifie

32. Registrar's Signature

and manner stated.

JUL 1 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI.D.

25365

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

PT. LOOKOUT RD. LEGNARDTONN, IMD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 1 THAMBLAN COLETTA U 4c. County of Death PRINCE GEORGE'S 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **LANHAM** DOCTORS HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 😿 F 59 577-64-5657 NOV 18 1947 WASHINGTON, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No PRINCE GEORGE'S BOWIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1103 PATRIOT LANE 20716 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No BLACK Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th HOUSE WIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARIAN HARVEY ROBERT HARVEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 PATRIOT LANE BOWIE, MARYLAND 20716 THILINATHAN THAMBIAN/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) LANDOVER, MARYLAND 7/14/2007 HARMONY CEMETERY J. B. JENKINS FUNERAL HOME 21. Signature Inera Service icensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 6, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f

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"natural",

ortant: If item 27 is marked other than "natuinjury or other traumatic event, the Medical

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

and Mental Hygi

Baltimore, Maryland 21215-0036

Momaine.

Examiner must be notified

Completed by Funeral Director

Be

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MD

Examiner the burial-tran attending physician for use as the buria Physician/Medical use as been signed by the should be detached Completed by certificate has birector, page 2 s ours after death.

eral Director: After this certific filled in by the funeral director, Be မ Certification:

The law requires that the death certificate be executed

or Attending Physician;

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1_Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital within 24 hours a Medical completely Registrar

Hanss on MD 29c. License number MDD 53718

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8/18 Good Luck Rd., Canham, M.D. 20706

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

32. Registrar's Signature

	Funeral Director
Dalumore, Malyland 21213-0020	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records. P.O. Box 68760.

sicia		1. Decedent's Neme (First, Middle, La					2. Date of De Month	eth Day	Yeer	3. Time of Death			
edica		FLORENC	CE M. U	SNER			July	13, 20	07 1	1:15 P.M			
mine	r	4a. Fecility Neme (If not institution, giv	re street end number)			4b. City, Town, or Location of Death 4c. County of Deeth							
		McCready Memoria 5. Social Security Number 6. S	-		ndev) If Under 1 Yea		field 8. Date of Bir	Some		(O. 1			
ral or			1 M 2 → F	o (In yrs. lest birti 90 Y	rs. Months Day		Feb. 3,	y, Year)	New Je	e (State or Foreign			
		Usual Residence of Decedent					1200.07						
N N	.	10a. State 10b. County Maryland Somer	·act	10c. City, Town						Inside City Limits 1 ☑ Yes 2 ☐ No			
	ပ္က	Maryland Somer 10e. Street end Number	sec	CLI	sfield 10f. Zip Code			10g. Citizen of V					
1	5	311 Myrtle Street			10.1 2.10 0000	21817			U.S.A.				
	nera	11. Marital Status	12. Was Decedent B	ever in U,S.	13. Was Decedent of If Yes, specify Cu		pecify Yes or No		e - American I				
3	2	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ☐ XNo		o Ricen, etc.)	Specify	ck, White, etc. v: Whit				
3	Completed	15. Decedent's Ed (Specify only highest gre	ducetion ede completed)	16e.	Decedent's Usual Occi Give kind of work don life. DO NOT use retii	upetion e during most of wo	16b. Kind of Business/Industry						
	Ē	Elementary/Secondary (0-12)	College (1-4or 5	+)		7/1							
		8 17. Fether's Neme (First, Middle, Last,)		Homemake	18. Mother's Nar	ne (First, Middle,	At Ho					
-	o Be	George Vanderbil	(Unkr										
		19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, 2											
		Charles H. Usner	(Son)		ll Myrtle S	Street - (Crisfiel	d, MD	21817				
	1	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	20b. Plece of cemetery	Disposition (Name of , crematory or other p	ace)	Date	20c. Location -	City or Town,	State			
once. To Be Completed by Funeral Director		4 □ Donation 5 □ Other (Specify	y)	Milford			7/17/07	Milford	d, NJ				
		21. Signature of Funda Service Liens 22. Name and Address of Facility Bradshaw & Sons Funeral Home											
	4		shaw, Jr.		306 W. Ma	ain St (Crisfiel	d, MD	21817				
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one ceuse on each lin	e.	ot enter the mode of dy	ring, such es cardiac	or respiretory a	rrest,	Int	proximate erval Between aset and Death			
ı		Immediate Cause (Final			ASCUD								
ı		disease or condition resulting in death)	a	Due to (or es e c	1								
1	<u>5</u>	_	h						 				
1	Examiner	Sequentially list conditions,	1	Due to (or as a co	onsequence of):								
1 7	<u>a</u>	Cause (Disease or injury											
1 2	eolcal	that initiated events resulting in death) Last		Due to (or as e co	nsequence of):				!				
100	riysician/n	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute											
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	à		UNU) C 31										
	ופו						24a. Was perfo	an autopsy rmed?	availat	eutopsy findings ole prior to etion of cause			
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mulator	-					00 Di(D	1 🗆 1		1 L Ye	es 2 No			
Completed		25 Was case referred to medical		examiner?									
S R	20 2		Hospital:	nt 2 ER/Outs	patient 3 DOA	d	ome 5 ☐ Resid	tence 6 Oth					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death Month 07 **Physician** George Viands М 24 07 1413 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, 1917) | Min. | Dec 26, 1919 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 F MD Director 219-03-8743 87 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f sh edical Examiner must be notified WV Mineral Wiley Ford 1 Yes x 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 26767 Rt. 1 Box 19 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

X Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married X ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: WWII Specify. Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tool and die maker Smith Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental F Important: If Item 27 is marked or any Injury or other traumatic even Sarah Elizabeth Rummer Viands Raymond H. Viands, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1 Box 19 Wiley Ford WV 26767 19a. Informant's Name/Relationship (Type. Print) Margaret Viands wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/27/2007 Restlawn Memorial Gardens MD LaVale 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Home, PA 23 print inter the dise se, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only ne cause on each line.

Immedia e Cause (Final disease or condition resulting in death)

Myocardial Infarction

a.

But to the disease or completion or condition resulting in death) 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Septic Syndrome Sequentially list conditions, if any leading to in modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be execute Urinary Tract Infection burial-tran Due to (or as a consequence of) physician a Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **a** 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 2 No 1∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifyli 29a. Certifier Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a completely

> State Registrar

(Check only one)

29b. Signature and title of certifi

Dr. Juan Arrisueno

31. Date filed (Month, Day, Year)

ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Seton Drive,

902

r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cumberland, Maryland 21502

D0023167

29d. Date signed (Month, Day, Year)

07/24/07

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year **Physician** Van Driessche Katherine 30M Rose 3 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Medica Jalisbur Wicomic CHIEN 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Hours 10/30/1929 New York Director 074-24-3838 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a, State 10h. County 10d. Inside City Limits Examiner must be notified at 1 XYes 2 No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1103 S. Schumaker Dr. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ Specify. white 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic <u>Housewife</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Dubas Dmitro Mazur ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 S. Schumaker Dr., Apt.6, Salis., MD 21804 Paul M. Van Driessche, Sr/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 4 □ Donation 5 □ Other (Specify) Colesville Cemetery 7/16/07 Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Dompoor CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VOUL ? /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 1 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 10 To the nosponse within 24 hours after death.

To the Funeral Director: After this of the funeral directors and the funeral directors. 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of optifier 29c. License number 29d. Date signed (Month, Day, Year) 00060715

1211

State Registrar

Jalali 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 East corrollst 32 Registrar's Signature

Salisbiry, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 9:35AM **Physician** OM WEBER LEWIS ONALD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 810 Calvin Street Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 6, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F Yrs. 227-42-4197 75 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Allegany Cumberland 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 810 Calvin Street 21502 USA death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Bace - American Indian. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Evamina 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify. Specify: 9 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter Carp. Local 1024 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elwood Earl Weber Lillian Walker Weber 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Weber 810 Calvin Street wife MD 21502 Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State Date Scarpelli Funeral Home, P.A. 7/29/2007 Cresaptown MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme ate Cause (Final Metas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 20 No 1 Inpatient 2 ER/Outpatient 3 DOA ome 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

5

State Registrar

29b. Signature and title of certific

30. Name and address of

AFAQ

31. Date filed (Month, Day, Year) 323 Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

KENTAVE

0060478

CUMBERLAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** WARNER 0612 M **JAMES** RUSSELL 19 07 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional Modecal Under I Year Vif Under 24 Hrs. Peninsula (e)icomico 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Country) 1 ▼M 2 □ F Director 234-54-1869 NOV. 25, 1936 WV Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ns 23a or 28a-f shor must be notified at 1 ¥Yes 2 □ No Director WV Upshur Buckhannon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RAILROAD AVENUE 125 26201 USA Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 📆 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) COAL MINER MINING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGIA NORA Lanham AMOS WARNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. P.O. BOX 1006, BUCKHANNON, WV 26201 JUDITH ANN WARNER - WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State HEAVNER CEMETERY 7-24-07 4 Donation 5 ☐ Other (Specify) BUCKHANNON, WV 21. Signature V Funeral Service Licensee 22. Name and Address of Facility SHORT FUNERAL SERVICES, 416 FEDERAL ST. MILTON, A xi 10068 Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or njury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the leath contificate be executed physician and s the burial-tran Box 68760分 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown has been signed 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? es 2 No page 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

100 E. Carrou St. SALISBURY Mg 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			Registrar	Lanti			lineale or i	Dealii		Reg. N	6. 0 0 1	3. Time of Death
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	nd 2 shu alth and 27 Is m r traum	Ċ	19a. Informant's Name/Relationshi BETTY A. SCOTT	p (Type, Print) DAUGHTER			ng Address (Street EAST MAIN				or Town, State, MD 2153	
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S	l or Attendi after death. Director: A in by the fu	ica	Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 280 Place of In	iury - At ho	me fam str	eet, factory, office	163 2		ion /Street a	and Number or B	ural Route Number,
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	Hospital		29a. Certifier 1 Certifying	Physician: To the best	of my know	wledge death	occurred at the tim	an data an	d place, and due t	a the cause/	c) and manner as	ctated
	To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dical	(Check only 2 Medical Exone)	caminer: On the basis of and manner st	of examinat	ion and/or inv	restigation, in my of	pinion, deal	th occurred at the	time, date ar	nd place, and due	to the cause(s)
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			30. Name and address of person w	no completed cause of	death (Item	23a) (Type	Print)	1				/
	3		S.L. SANDHIR, MI) 48 TARN	TERRA	CE F	ROSTBURG	, MD	21532			
	Sta		31. Date filed (Month, Day, Year)	nn7 32. Registr	rar's Signat	ture						
	Registr	ar	SOL O T S	All History	ar give	A STATE OF THE PARTY OF THE PAR	The state of the s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item# 5 07/23/07 State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Cecil Co Health rjw Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 13, 2007 4c. County of Death William Nelson Woodrow /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Grac Havre ford Memoria Birthplace (State or Foreign Country) If Under 2 8. Date of Birth (Month, Day, Year) Social Security Number 2-24-831 **Funeral** Min. 1 M 2 □ F Months Davs 1925 81 4, Maryland Dec. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2x No Conowingo Cecil Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 21918 1589 Liberty Grove Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or Iten 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White þ 3 □ Widowed 4 □ Divorced Completed d other than "natur event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Port of Wilmington, Elementary/Secondary (0-12) College (1-4or 5+) Delaware Mechanic Eight Years 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Donahue William Noble Woodrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 21917 88 Frist Road, Colora, Maryland John W. Woodrow 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Liberty Grove, Maryland 07/18/07 Harmony Chapel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. THERESON ST. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final unknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Esquentially liet eo rettione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Head and Neck, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier St NUS Name and address of person who completed cause of death (Item 23a) (Type, Print) VA Maryland Health Care System, Perry Point, MD 21902 Hem Mittar 31. Date filed (Month, Day, Year) 1 8 State 2007 JUL Registrar

DHMH 17 Rev 1/2001

Jame Known to Physician: Woodrow

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Funeral	Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) If Under 1 Ye		8. Date of Birth(M	M/DD/YYYY) 9. Birt Foreig	hplace (State or
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Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other transity or other transity or other transity or other transity.	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens		22 Name and Addr	ess of Facility			
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cuted nd ransit	d.						
be exercician a	X UNPENDED	#23a,27.perME.ge	870, 8/2/07 TT			Loo i Di i i dadha	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	nancy Fetal death	3 Ectopic pregnar	псу	23d. Date of delive Month	Day Year
× 68 h certi tendin	past 12 months?	4 Pregnant at time of de	4				
Bo. te death		g Unknown contributing to death but not re	equiting in the underlying car	se given in Part I	23e. Did toba	acco use contribute t	to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the starter death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Part II. Other significant conditions	contributing to death but not re	esalting in the andenying out	gromm acc			obably 4 Unknown
ds, l					24a. Was an		autopsy findings available completion of cause of
COFC law re has be					autopsy perform 11 Yes 2	ed? death?	
Re: The ifficate			26.F	Place of Death (Check of		V 100	
/ital		Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: Nursin	g Home 5 R	esidence 6 🗸 Oth	ner: Scene
n of Vital ding Physician: h. : After this certif	27 Manner of Death	28a. Date of Injury (Month, Day,Year)	1 ' 1 ,	Injury at Work?	28d. Describe ho	w injury occurred	
ion tendin eath.	1 X Natural 5 Pending 2 Accident Investigat	ion		Yes 2 No			Dural Davida Number City
ivision At after d	3 Suicide 6 Could not	be 28e. Place of Injury - At h	ome, farm, street, factory, off	ice building, etc.	28f. Location (Str or Town, Sta	reet and Number or l ite)	Rural Route Number, City
Division ospital or Attend hours after death uneral Director: ly filled in by the I		(Specify) Jun: To the best of my knowled	tro, dooth accurred at the tim	e date and place and	due to the cause	(s) and manner as st	tated.
the Ho nin 24 the Fu	29a. Certifier 1 Certifying Physic (neck only) 2 Medical Examine 29b. Signature and title of certifier	r:On the basis of examination a	and/or investigation, in my op	inion, death occurred a	t the time, date a	nd place, and due to	the cause(s)
To the within To the comple	29b. Signature and title of certifier	and manner stated.		cense number		29d. Date signed (A	
	/ ///		C).C.M.E.		July 23, 2007	
OCME	30. Name and address of person who				ID 04004		
		eputy Chief Medical Exa		reet, Baltimore, M	ID 21201		
St Regist	te 31. Date filed (Month 14. Ye2) 5	2007 32. Restrar's Signat	A body				
			7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	ı	1 - State Registrar	State of Marylar		artment of		nd Mental H	lygiene Reg. No		24539
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of Month			3. Time of Death
/Medi	cal		LIAM JACOB WI	HITE					007	11:52 P ^M
Examir	ner	4a. Facility Name (If not institution, give st			4b. City, Town,	or Location of I HESDA	Death	40	County of Death	
Funeral Director	•	NATIONAL NAVAL ME 5. Social Security Number 6. Sex 1 💆	M 2 F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Min. (Month,	Birth Day, Year	Cos	place (State or Foreign intry) yland
p p		Usual Residence of Decedent 10a. State 10b. County	10c Cit	ly, Town or Lo	cation					10d. Inside City Limits
Aaryla f eho	ō	VA Arlingt		one	Cation					1 Tyes 2 No
r 28a-	Director	10e. Street and Number	OII IN	One	10f. Zip Code			10g. Ci	itizen of What Cou	untry?
th witt	aiD	1212 North Stua	rt Street		2220	1		US	SA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "netural", or itema 23e or 28e-f ehow many injury or other traumatic event, if a Medical Exercitar man be retilled at once.	by Funeral	11. Marital Status 1: 12 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Amed Forces? □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of if Yes, specify Cul 1 ☐ Yes 2 🛣 No		n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Ca	
turai		15. Decedent's Educ		16a. Dece	dent's Usual Occu	pation		16b. h	Kind of Business/I	
d within 72 giene. er than "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12) 0		(Give	kind of work done DO NOT use retire	during most o	f working	N/		
al Hyg	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Mic	dle, Maidei	n Sumame)	
y id ould to Ment	2	William Paul W					ia F. A			
d 2 sh d 2 sh th and 7 ts m traum		19a. Informant's Name/Relationship (Type William P. White	· · · · · · · · · · · · · · · · · · ·	1			or Rural Route Nu			
Heali Heali tem 2		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		Date		on VA 2.	
Pages ent of nt: #f i		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		matory or other plants. P.	1	//14/200	7	Fairfa	v 177
permit. Departm Importa		21. Signature Jung al Servic Jicen le	tul	22	2. Name and Addr	ess of Facility		Men	orial 1	Funeral Hn
Physician /Medical Examiner percented physician and physic	dicai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, that year and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	cause on each line.	E PREMA	er the mode of dy	ing, such as ca	rdiac or respiratoi	y arrest,		Approximate Interval Between Onset and Death
ath certific thending p	Physician/Medi	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregn: 1 Live birth 2 Feta 4 Pregnant at time of c	Il death 3[Ectopic pregnand	су			23d. Date of delin	very Day Year
uires that the de	þ	Part II. Other significent conditions cont	ributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.			77	the cause of death?
sician: The law require scertificate has been signirector, page 2 should b	Completed							utopsy erformed?	prior to c death?	topsy findings available ompletion of cause of
ician certific ector,	Be	25. Was case referred to medical examiner?	spital:				f Death (Check or	ly one)		
Phys rthis ral dir	2	1 Yes 2 XNo	1 X Inpatient 2	ER/Outpatier	1 3LI DOA		ing Home 5 F		6 Other (Spec	ufy)
th. After	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	W	ork? ∃Yes 2No		oe now inju	ny occurred	
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str			28f. Location	n (Street a Town, Stat		ral Route Number,
he Hospit in 24 hour he Funera pletely fille	edicai	29a, Certifier (Check only one) 1 Certifying Physical Examination (Check one) 1 Certifying Physical Examination (Chec	cian: To the best of my known on the basis of examinating and manner stated.	owledge, death	n occurred at the vestigation, in my	time, date and i opinion, death	place, and due to occurred at the tir	the cause(s	s) and manner as nd place, and due	stated. to the cause(s)
To t Withi To t	Σ	29b. Signatule and title of certifier	10	^		se number		29d. Da	ate signed (Month	Day, Year)
.)		MAX	CID PH	ب	D-65	417		C	1110	LOO/
		30. Name and address of person who con	pleted cause of death (Iter	n 23a) (Type,	Print)		TIONAL N			CENTER
Sta	ato		IAJ MC USA 32. Signistrar's Signa	ature		BE	ETHESDA M	D 208	89-5600	
Regist		31. Date filed (Month, Day, Year) JUL 16 200	17 Halue	K. A	neuts 1					

07-05657

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2	00	7	2	1	5	\$0000 P	

William Henry Webe		Red No.
	For State egistrar I. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
''ysician/ Med xaminer	William H. Weber, Jr.	July 23, 2007
med xame	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location Beltsviile	of Death Prince George's
	11505 Cordwall Drive	ler 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral	5. Social Security Number 6. Sex Months Days Hour	s Min. Aug. 11,1985 For Mary land
Director	212-31-2001 1AM 2 F	10d. Inside City Limits
a	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. C	1 Yes 2 No
d how a	Maryland IIInec George -	
arylan at on at on ecto	10e. Street and Number 20705	10g. Citizen of What Country? United States
death with the Maryland or items 23a or 28a-f show must he notified at once.	11505 Cordwall Drive 20703	rigin? (Specify Yes or No- 14. Race - American Indian, Black,
h with	11. Marrial Status Armed Forces? If Yes, specify Cuban, Mexica	I.Thite
or ite	Yes 2 X No special of Yes, Give Year	fy: Specify:
nral"	Widowed 4 Divorces or Dates: Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO No.	
72 hou at Exa	Elementary/Secondary (0-12) College (1-4 or 5+) Technician	Secuirty Co.
otthin ene.	12 18.Moti	ner's Name (First, Middle, Maiden Surname)
15-0 filed w Hygid d other		rolyn M. Fish
Baltimore, MD 21215-0036 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Metalla Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an important: If item 27 is marked other than "natural", or items 23a or 28a-f show an important: If item 27 is marked other than "natural", or items 23a or 28a-f show an important if items 25a or 28a-f show an important if items 25a or 28a-f show an important in the modified at once.	19b. Mailing Address (Street and N	Number of Rural Route Number, City of Town, State, Zip Code) 70705 Naryland 20705
AD 2 short and 27 is rumatic	Carolyli M. Weber in the state of comparing	Date 20c. Location - City or Town, State
e, N I and Health	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Metropolitan Cremato	ry 7/25/2007 Alexandria, Virginia
Pages rent of	4 Donation 5 Other Specify:	Glity of Financial Home PA
salti epartu nports	21. Signature of Buneral Service Ligerysee Donald V. Bor	Wardt Funeral Home, PA 1111 Road Beltsville, Maryland20705 1111 Road Beltsville, Maryland20705
m a a = .=	23a Part I. Firer the disease, or complications that caused the death. Do not enter the mode of dying, such	as cardiac or respiratory arrest, shock, or heart Between Onset and
√ sician ⊿edical	failufe. List only one cause on each mine.	Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. **Def OIIT INCOALCACTOR MAY COSTING SEASON TO BE TO SEASON TO SEAS	
	Sequentially list conditions, Farty Leading to immediate Due to (or as a consequence of):	
	if any, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause c.	
- is	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.	
Division of Vital Records, P.O. Box 68760, of the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.		
0, e be es ysiciar burial		23d. Date of delivery Month Day Year
Box 68760 e death certificate I the attending physe	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 E	ctopic pregnancy Month Day
ox 6 ath cer attendi	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown	the support death?
the der	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Unknown
P.O.	<u></u>	24b Were autopsy findings available
ds,		autopsy performed? prior to completion of cause of death?
COF law r e has b		1 • Yes 2 No 1 • Yes 2 No
Re I: The tificate or, pag	26. Mas case referred to medical	Death (Check only one) er₄ Nursing Home 5 Residence 6 ✔ Other: Scene
/ital	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	
of \ing Phy and After the uneral	27. Manner of Death 28a, Date of Injury 28b, Time of Injury 200, Time of Injury	2 X No unk
ion tendii tor: A	The second of th	ling, etc. 28f. Location (Street and Number or Rural Route Number, City
Division of Vital Records, pital or Attending Physician: The law require eral Director: After this certificate has been sifiled in by the funeral director, page 2 should	Suicide 6 A Could not be determined (Specify) found at residence	11505 Cordwall Dr. Beltsville, MD
Divisior Divisior 4 hours after death Fameral Director:		and place, and due to the cause(s) and manner as stated.
To the Howithin 24 P. To the Function	one) 2 Medical Examiner: On the basis of examination and/or investigation, in the parties of examination and/or investigation and or investiga	Coll Pate signed (Month Day Year)
To the comple	29b. Signature and title of certifier 29b. Signature and title of certifier	umber 250, 54, 2007
	6.C.M.	E. July 24, 2007
OCME	30. Name and address of person who completed cause of death (Item 23a)	Baltimore, MD 21201
-	Mary G. Ripple MD. Deputy Chief Medical Examiner 1117 enin outcot,	
Pegis	ate 31. Date into (MONTAGE Z) 6 200/ Stage 200 / Stage	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7/13/200^{Day} 2:55p Weiner Theresa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/2/1912 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2√□ F 94 213-42-5299 Hungáry Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examina. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Silver Spring Md. Montgomery 10f. Zip Code 20901 10e. Street and Number 10g. Citizen of What Country? 10030 Renfrew Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No <u>م</u> Specify. 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samue1 Cornelia Grosz ပ Feldman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5~Snug~Hill~Court~Potomac,~Md.~20854Perlin/daughter Annette 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Lebanon Cemetery 7/15/07 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Md 21. Signature of Funeral Servi 22 Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Pneumonia **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an alzheimers disease autopsy performed? X□ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Afte 1 XNatural 5 Pending investigation Injury in 24 hours are: the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760

State Registrar

31. Date filed (Month, Day, Year)

JUL 17

2007

30. Name and address of person who completed crute of death (Item 23a) (Type, Print)

Dr.Alan R. Segal 1517 Hugo Circle Si Hugo Circle Silver Spring, Md. 32 Degistrar's Signature

D52261

7/13/07

07-05468 Larry D Wilson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arry D Wilson	1-	State of Maryland / De	Certificate o	f Death			40	01 6104
Physician	R	eqistrar . Decedent's Name (First, Middle,Last)	Jer tiricate of	Death		2 Date of Deat	g. No.	3. Time of Death
Aledical Examine	er	Larry D	W	ilson		Month July 16, 20	Day Year 007	1736 hrs
	4	a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County of Dea	1
		Southern Maryland Hospital		Clinton	ar If Under 24Hrs	No Date of Birt	h(MM/DD/YYYY) 9.1	
Funeral Director	1	21-80-1037 1 X M 2 F 4	yrs. last birthday)	If Under 1 Year Months Day s.		1.	/1959 For	eign Maryland Country)
		Jsual Residence of Decedent 0a. State 10b. County 10c.	City, Town or Loca	ition				10d. Inside City Limits
Ow any		aryland Prince George I	•					1 X Yes 2 No
Maryland 28a-f show d at once.	֓֞֞֞֓֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֓	Oe. Street and Number	opper me	10f. Zip Code		1	0g. Citizen of What C	ountry?
he Ma iffed	ബ-	7314 Aginies Avenue		207	72	- 5	USA	
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	ē	Marital Status 12. Was Decedent Ever	in U.S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No	- 14. Race - Am White, etc	erican Indian, Black,
death death	<u> </u>	1 Yes 2 X	No			o radan, oto.,		
s'after ral",	<u>a</u> -	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete		Yes 2 X Nent's Usual Occupa		work done	Specify: B	
hours "natu Exan	盲	Elementary/Secondary (0-12) College (1-4 or 5+)	during r	most of working life	e. DO NOT use re	tired)		THE ME
36 thin 72 than than	Completed	12	I	Painter			Self-Em	ployed
e, MD 21215-0036 I and 2 should be filed within 72 hours after Health and Mental Hygiene Titem 27 is marked other than "natural", or traumatic event, the Medical Examiner	5	17. Father's Name (First, Middle, Last)					Maiden Surname)	
2121 uld be fil Mental I marked c event,	a		Wilson S	Sr.	Mildre	Pural Pouta Nur		Harper late, Zip Cod 20772
ID 2. should and M 3 is m matic e	٩	19a. Informant's Name/Relationship (Type, Print)	7314	Aainies (Sile	s Ave.	Upper	Marlboro	,Maryland
ore, MD es 1 and 2 sho of Health and If item 27 is her traumati			20b. Place of Dispo	osition (Name of c	emetery,	Date	20c. Location - City	or Town, State
DOFE ages 1 nt of H	- 1	1 X Burial 2 Cremation 3 Removal from State	crematory or o		7/	26/07	Brandyw	ine,Marylan
Baltimore, MI permit Pages 1 and 2 s Department of Health a Important: If item 27	+	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	ASDUL Y	Name and Addre	ss of Facility A C	lams Fu	neral Ho	me PA
Dep. Dep.	-	$\mathcal{L}(\mathcal{L}(\mathcal{L}(\mathcal{L}(\mathcal{L}(\mathcal{L}(\mathcal{L}(\mathcal{L}($	91 120	0605 Aa	uasco F	Rd.Aαua	sco, Mary	land 2060 <u>8</u>
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter	the mode of dying	g, such as cardiac	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
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0, e be executed sician and burial - transit	ledical	X UNPENDED #MENDED, PII, 27	,28a-f, per	ME,g870, 8	/6/07 TT			
760, ficate be physical the buri	We .	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of	of pregnancy		Ectopic preg	nancy	23d. Date of del Month	very Day Year
x 68 h certi ending use as	Physician/M	past 12 months?	6 -141-	Other (Specify)			1	
BO) e deatl the att	hys	1 Yes 2 No 9 Unknown 9 Unknown	12		a siven in Port I	23e Did	tobacco use contribut	e to the cause of death?
that the	by	Part II. Other significant conditions contributing to death bu	it not resulting in the	e underlying causi	e giveiriii Fatti.	l l		Probably 4 Unknown
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dS, Fraguires and be alled be	ted	Emphysema			_	24a. Was	s an 24b. Wer	e autopsy findings available
cords, F law requires 1 has been sign e 2 should be	npleted	Emphysema				24a. Was auto perf	s an 24b. Wer ppsy prio ormed? dear	to completion of cause of th?
Records, F. The law requires ifficate has been sign.	Completed			26. Pla	ice of Death (Che	24a. Was auto perf 1 🗸 Yes	s an 24b. Wer ppsy prio ormed? dear	to completion of cause of
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of Vital Records, F g Physician: The law requires: ther this certificate has been sign neral director, page 2 should be	To Be Completed	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient		ent 3 DOA of Injury 28c. Ir	Other Nur njury at Work?	24a. Was auto perfu 1 ✓ Yes ck only one)	s an 24b. Wer prio cormed? 2 No 1	r to completion of cause of the head of th
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DHMH 17 Rev 1/2001

Registrar

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-trar attending physician for use as the buria

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: in 24 hours after death.

the Funeral Director; After this certifica within 24 100

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2007 9:28 A M July 10, Emily H. Wilson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Spa Creek Center 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day,) 7/8/1904 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 1□M 2XF South Carolina 103 220-38-5565 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Directo Maryland | Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4020 Solomons Island Rd. 20776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No ^{Specify:}White ò 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 + years Physician Medica1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christopher Hammond Mary Gwynn ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Wilson/ Son 4020 Solomons Island Rd., Harwood, MD 20776 20a. Method of Disposition
1 ☐ Burial 2XX remation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Kalas Crematory 7/11/07 Edgewater, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home What I Uul 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 🗓 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 1□ Yes 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Juring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signatu nd title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Ridgely Ave., Aditya Chopra, M.D. Ste. 231, Annapolis, MD 21401 31. Date filed (Month, Day, Year) JUL 12 2007 legistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

yч	3, 2007	AA		State of Ma	aryland	d / Depa	artment of H	lealth a	and Me	ental Hy	giene		
			For State Registrar			Cei	rtificate of	Death			Reg. No.	2007	21.51.5
	Physici	an	1. Decedent's Name (First, Middle,	Last)						Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Edward, Was	land						July	6	FOOG	234 AM
	Examin	ner	4a. Facility Name (If not institution,	rive street and number)	10	\	4b. City, Town, o	r Location of	of Death	7	4c.	County of Death	
100			5. Social Security Number 6	report 18 1/2	ie (In vrs. li	ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	th	9. Birth	place (State or Foreign
	Funeral Director		082-26-6050	1 ⊠ M 2□F	76	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	Cou	ntry) NY
7	2		Usual Residence of Decedent		T. 0.					way o,	1231		
o Charle	show	<u>_</u>	10a. State 10b. County MD Anne A	Arundel	10c. City	, Town or Lo			\ 1.				10d. Inside City Limits 1 ☐ Yes 2X No
h 0 4	28a-f	Director	10e. Street and Number	Tarder			10f. Zip Code	rna P	ark		10a Citi:	zen of What Cou	
i i	3a or	اق	1307 North Road					1146			rog. Otta		
decolo	ms 2;	Funeral	11. Marital Status	12. Was Decedent		S. 13. 1	Was Decedent of H If Yes, specify Cub		igin? (Spec	cify Yes or No	- 1	US 14. Race - Ameri	can Indian,
9	or Ite		1 ☐ Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 ☐ If Yes, Give	No		in Yes, specily Cub. 1 □ Yes 2 🕱 No	an, mexicar Specify:		tican, etc.)		Black, White, Specify:	white
	ural",	d by	3 Widowed 4 Divorced	Year or Dates:	Kore	ea							
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III Z IZ I 3-0030	mode of mode withing the mode within marked other than imatic event, the MG	BeC	17. Father's Name (First, Middle, La					18. Mothe	er's Name	(First, Middle,			•
2 4	Menta	5	Paul M. Weyand					Cla	ire S	Stanbro	W		
an yla	1 8 S		19a. Informant's Name/Relationship	, ,,		19b. Mailir	ng Address (Street	and Numbe	er or Rural	Route Numbe	er, City oi	r Town, State, Zi	o Code)
2, 5	Health tem 27 i		Juanita B. Weyar 20a. Method of Disposition	nd/Wife	20h Pi	1307	North R	oad,		ma Par		D 21146 cation - City or T	
	ponnit. Tages I am Important: If item 2 any Injury or other once.		1 Burial 2 ☐ Cremation 3				esition (Name of matory or other place Cans Ceme		July	• • • •		•	
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	-Œ		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	d the death							-	Approximate Interval Between
Р	hysician		Immediate Cause (Final disease or condition	Tito	46.D	1-1	20004	cha	- 0				Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequ	ence of):	11110	_	7				2000
	xaminer	١	Sequentially list conditions,	b									
70	nsit	Examiner	Sequentially list conditions, if any, leading to immediate each. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ierice oi).							
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The law requires that the death continue to executed	physician and the burial-transit	dical		d									
	ng ph as th	/ledi	IF FEMALE:								1		
ָאַר אָל מ	been signed by the attending I should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth	2 Fetal	death 3	Ectopic pregnanc	y			2	3d. Date of deliving	ery Day Year
5	the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	eath 5	Other (specify) _					Wolld	Day Teal
- to4	ed by detac		Part II. Other significant condition	s contributing to death b	out not resu	Ilting in the u	nderlying cause giv	en in Part I		23e. Did to	obacco u	se contribute to	he cause of death?
Olds,	sign Id be	d by								10	Yes 2[□ No 3 □ Pro	bably Dunknown
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hyelo	his ce I direc	To	examiner? 1 ☐ Yes ♣4o	Hospital:	ent 2 🗆 I	ER/Outpatier	nt 3□ DOA Oth	ier: 4□Nu	ursing Hom	ne 5⊟Resid	dence 6	i □Other (Spec	fy)
	or Affer t		27. Manner of Death 1	28a. Date of Inju (Month, Da	ıry ay Year)	28b. Time o Injury	Wor			8d. Describe I	how injury	y occurred	
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	after o	Certification:	4 ☐ Homicide determine	building, et	c. (Specify	ne, rann, su	reet, factory, office		20	City or Tov	wn, State,))	al Route Number,
DIVISION VICE	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s		29a. Certifier 1 Sertifying	Physician: To the best	of my know	wledge, deat	h occurred at the ti	me, date ar	nd place, a	and due to the	cause(s)	and manner as	stated.
P P	n 24 h	Medical	(Check only 2 Medical Ex	caminer: On the basis o and manner st	of examinat ated.	tion and/or in	vestigation, in my	opinion, dea	ath occurre	ed at the time,	date and	place, and due	to the cause(s)
÷ c	To t	Ž	29b. Signature and title of certifier				29c. Licens	e number			29d. Date	e signed (Month	Day, Year)
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1	V/V	X	Name and address of person wh	no completed cause of d	1		Print)	١١.			10:		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regi s	ar's Signal	ture	H. Ba	141 m	Dra-	WO 3	1190		
	Registr		JUL 1	1 2007	du.	K.	Sporte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 20b c per fb 870 8-7-07 vt
State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** NORMAN BENJAMIN, JR. JULY 30 2007 17:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7025 DEERFIELD ROAD PIKESVILLE BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 66 433-62-9385 8/16/1940 Director LOUISIANA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ▼No BALTIMORE PIKESVILLE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7025 DEERFIELD ROAD 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2√2 No þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the M <u>once.</u> PAINTER US COAST GUARD 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NORMAN BENJAMIN, IE HARRIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTIE BENJAMIN / 7025 DEERFIELD ROAD, PIKESVILLE, MD 21208 WIFE 20a. Method of Disposition Date Place of Disposition (Name of Carlet Grant Carlet C 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 8/06/07 DALTIMORE CO., MD 22. Name and Address of Facility 21. Signature of Suneral Service Licenses HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, Ther the disease, or complications that caused the death k, or heart failure. List only one cause on each line. Immediate use (Final disease condition resulting in death) ra Physician ta month) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No autopsy performed? 1□ Yes 25 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 🗌 Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 attending physician for use as the buria certificate has treetor, page 2 s within 24 hours after death

To the Funeral Director:
completely filled in by the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

ral", or items 23a or 28a-f sl Examiner must be notified

"natural",

the Medical

State Registrar

29b. Signature and title of certifier

AUG

Year) 32. Registrar's Signature 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State

Registrar

Laron Locke MD. Assistant Medical Examiner

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who come teed cause of death (Item 23a)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 28, 2007

AUG 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28f per doc 8870 8-1-07 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16:08 M DORIS DELANO SULLIVAN BISSETT JUL 2007 29 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE, MARYLMA SINAI N/A 8. Date of Birth (Month, Day, Year)
Mac 14, 1927 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2**X**F 80 Maryland Yrs. 214-22-9305 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2**Y** No Maryland Baltimore County Baltimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1233 Lake Falls Road 21210 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry pernnt. Pages 1 and 2 should be filed within 72 ht Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical i once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County College (1-4or 5+) Elementary/Secondary (0-12) Secondary School Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) timore, Maryland Daniel Nicholas Sullivan Helen Delano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mc. Robert T. Bissett (Husband) 1233 Lake Falls Rd., Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Green Mount Cemetery Aug 1, 2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signa un Fin-ri Se colingen woon MITCHELL WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TRAIT INFECTION URIMART Physician /Medical Due to (or as a consequence of): Examiner ACUTE RENA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, FALL, SHOULDER FRACTURE, HIP FRACTURE 1 Yes 2 No 3 Probably 4 Junknown Completed HYPERTENSION, ATRIAL FIBRILATION, STROKE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 1☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈Yes 2 No Certification: To After this 28d. Describe how injury occurred home 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation July 1, 2007 UN KNOWNM 1 ☐ Yes 2 🕅 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and 12233 Take Part Road City or Town, State) 4 Homicide Home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

PATEL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL OF

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31. Date filed (Month, Day, Year)

D64957

BALTIMORE, BALTIMORE, MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Thomas Edward Byerly 2007 01:48 JULY 30 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birth (Month, Day, Year)
Oct. 27, 1924 of If Under 24 Hrs. 9. Birthplace (State or Foreign Country) District Age (In yrs. last birthday, 5. Social Security Number **Funeral** Hours XXM 2 F 216-20-6855 82 Director Columbia Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.

m 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes XXNo by Funeral Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. F8 21030 U.S.A. 13801 York Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. XXYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married Married 1 ☐ Yes **XX**No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) President Manufacturing Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna M. Biddison John Houck Byerly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13801 York Rd.; Cockeysville, MD 21030 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar important: If Item 27 is any injury or other trau once. Bettie A. Byerly / Wife 13801 York 20b. Place of Disposition (Name of cometery, crematory or other place)
Druid Ridge
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 8/2/07 Pikesville, MD 4 ☐ Donation _5 ☐ Other (Specify) 21. Signature present ervice Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. mere 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myagardia 3415 disease or condition resulting in death) /Medical Due to (or as a Insequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): P.O. Box 68760, physician sthe burial Physician/Medical SS 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year for 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1∐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death Check onl ove) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To Date of Injury (Month, Day Year) Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 5 Pending investigation Natura 1 ☐ Yes 2 ☐ No 2 ☐ Accident death neral Director: / the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours at er d To the Funeral Direct completely filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Consider the cause of the date of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar

29b. Signature as

GBMC frey 31. Date filed (Month, Day,)
AUG 0 1 32. Registrar's Signature

e and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22,20t Montk **Physician** 4a. Facility Name (It not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA timore laxy/and Greneral HUSPHAL If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 F Yrs. 21,1964 217-94-3442 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 shoup be med made in the permit. Pages 1 and 2 shoup be partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 No Director MD NIA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21223 518 Hurley Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ģ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation ***.
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) NIA Never Worked 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Burns Burns ၉ amar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hurley Ave, Bala md 21223 A. Boyd Joseph Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cutansulle, IND July 28,2007 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fred Hetin Fair Baltom 121229 Ringlda 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final troperitoneal Hematoma **Physician** disease or condition resulting in death) /Medical taphylococcus Aureus Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Immunodeficiency Syntrome attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy performed res 2 No certificate **Division or Vital** Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hayras ML 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Q AUG 0 1 2007 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIHWA, perFH, CS/0, 8/9/07, WS

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 30 AM 2 Z 007 /Medical 4a/Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner Himare 5. Social Security Number 8. Date of Birt 9-25-19 (Month, Day, Year) 15-1914 -1914 9. Birthplace (State or Foreign Country) Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2√ F 215-16-9301 92 Yrs Director VA Usual Residence of Decedent with the Maryland il Hygiene. other than "netural", or Iteme 23a or 28a-f ehow vent, the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director MD n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Peges 1 and 2 should be filed within 72 hours after death v Deperment of Heelih and Mental Hygiene. Importent: If item 27 is marked other than "netural", or iteme 23a any injury or other traumatic event, the Medical Examinat must app. 3323 Ingleside Avenue 21215 USA Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-1 Yes 2 No Specify Specify: <u>۾</u> 3 Widowed 4 □ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Janitor Baltimore City School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Jones unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Holt/ Daughter 3323 Inclesdie Ave., Baltimore, MD 21<u>215</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t ☐ Buriar 2 ☐ Cremation 3 ☐ Removal from State onation 5 Other (Specify) 8-7-07 oudon Park Cem. Balto. MD 22. Name and Address of Facility Wylie F/ H P.A. of Balto.Co. 21 Signature of Funera Service Lice and 9200 Liberty Rd., Randallstown, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, NEUMONIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a nonsequence of) Examine attending physicien and for use as the burial-transit The taw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð ONGESTIVE ALLURG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has in by the funeral director, page 2 autopsy performed 212 No 1 Yes 2 No 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide To the Funeral I 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30 28595 Green Maur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO MD 21208 AKHANI, SHITE 203. 2835 SMITH TASNELM 31. Date filed (Month, Day, Year) 92. Registrar's Signature State Registrar AUG 0 1 2007 DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 12:50 pm Anne Cerny July 28 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Baltimore Stella Maris Hospice Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 325-03-5349 Illinois Oct 18 1915 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ILLake Antioch 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 42720 Addison Lane 60002 USA 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1aw paralegal secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Hetver Anna Houf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Cerny (son) 42720 Addison Ln., Antioch, IL 60002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State All County Cremation 8-3-07 Sykesville, 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paige Haight Derbert P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final rok Quyo disease or condition resulting Sequent if any, le Cause (I that initial resulting exar 1 🔲

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show aminer must be notified at

"natural",

or other traumatic event, the Medical

Director

Funeral

Completed by

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be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

Is marked

Health em 27

permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other i once.

Be Completed by Physician/Medical Examiner burial-transi Physician: The law requires that the death certificate be executed the use been signed by the should be detached certificate has been page 2 s Medical Certification: To Hospital or Attending

Division or Vital Records, P.O. Box 68760,

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IF	FEMALI	E:			
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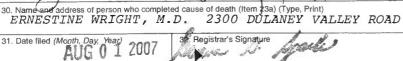
resulting in death)	Due to (or as a conseq	uence of):				
Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b Due to (or as a conseq	uence of):				
that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome pf pregn. 1□Live birth 2□Feta 4□Pregnant at time of c	al death 3 □Ectopic			23d. Date of deliver Month	y Day Year
Part II. Other significant conditions of	contributing to death but not res	ulting in the undertying	cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the	e cause of death? ably 4 ∐Unknowr
	_			24a. Was an autopsy performed	prior to com death?	nsy findings available pletion of cause of 기계 No
25. Was case referred to medical			26. Place of De	ath Check onl one		
examiner? 1 ☐ Yes 2☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🛭	Other: 4 Nursing I	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory)	ry, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
29b. Signature and title of certifier	. 0	1 1 2	9c. License number	29d.	Date signed (Month, I	Day, Year)

State

within 24 hours after death.

To the Funeral Director: A

31. Date filed (Month, Day, Y



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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician ,2007 11:35 P M Inei ta ain V2994 106 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Care Center Essex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 14, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 86 218-63-3246 Yrs. Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Director Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1635 Mussula Rd. 21286 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Beichel Morton Wessels and M 17 Is⊤r 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau 748 Sue Grove Rd. Baltimore, Maryland 21221 Donna Gentry (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/1/2007 Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 21. Signature of Funeral Service Licenses Maryland 21221 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Rose reuta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discussion of Figure 1) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 N 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Harsing Home 5 Residence 6 Other (Specify) 2 10 Certification: To 1 Yes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural nours after death.

neral Director: All y filled in by the fu 1 Tyes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier

29b. Signature and title of certified

Elloul

AUG 0

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Twocy +508 Glen Bornie, Ald 21061

and manner stated.

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elacus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State State	of Maryland	-	rtment of H						
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei		Jean	2. Date of Death	g. No. 2	97	3; Time of De	ath
	Physicia	an						Month July	Day 26, 2	Year	8:05P	M
	/Medic	al	Frances H. Connolly	numbor)	T	4b City Town or	Location of Death	July	4c. County			
	Examin	er	4a. Facility Name (If not institution, give street and	number)		40. Oity, Town, Oi				1tim		
-			Stella Maris Hospice 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	Timonium If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or F	oreign
	Funeral Director		212-38-0706		Yrs.	Months Days	Hours Min.	Feb. 8,	1937		aryland	
Н			Usual Residence of Decedent	70								
	yland now at		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City I	
	a-f st	tor	Maryland Baltimore			Perry 1	Hall				1 ☐ Yes 2	No No
	or 28;	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	What Cou	intry?	
	72 hours after death with the Maryland 'naturalr', or Items 23a or 28a-f show dical Examiner must be notified at	<u> </u>	4923 Marchwood Ct.			21	128			S.		
	ems er mu	Funeral	11. Marital Status 12. Was D Armed	ecedent Ever in U.S Forces?	3. 13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Ameri k, White	ican Indian, , etc.	
0	after or It		If Yes.	es 2 🕅 No Give		1 □ Yes 2 No	Specify:		Specify	/: TTI		
2-003p	ural",	d by		r Dates:	10. D	1	-4!	T.		wn.		
<u> </u>	"nati	Completed	15. Decedent's Education (Specify only highest grade complete	ed)	(Give	lent's Usual Occup kind of work done DO NOT use retired	durina most of work	ring	l6b. Kind of Bi	usiness/ir	naustry	
V	within	E D	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	mc. I	Homemake	•		Own	ι Ηοπ	ne .	
Z	filed within Hygiene. other than ' ent, the Me		17. Father's Name (First, Middle, Last)			Homemake		e (First, Middle, N				
aud	d be i	Be c	Andrew Maszczynski				Mar	v Unkno	רועור			
Ě	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	မ	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Rui			State, Zi	ip Code)	
<u> </u>	d 2 s th an 27 ls trau		John Connolly (Husband	וו			od Ct., P		•		•	
a)	1 an Heal tem 2		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of	1		20c. Location			
Saltimor	ages int of t: If ii		1 ☐ Burial 2 【Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State		natory or other plac	· i	3/2007 F	201+ima	ro M	aryland	
	artme artme ortani injun		21. Signature of Fundal Service Licensee	вау		Crematory 2. Name and Addre	ss of Facility Sc					
ğ	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra		Illy Tilla				r Road,					
			23a. Part1. Enter the disease, or complications th	at caused the death.							Approximate	
			shock, or heart failure. List only one cause of	on each line.							Interval Betwe Onset and De	
	Physician /Medical		disease or condition a. BRE	to (or as a consequent								
	Examiner		Due	to (or as a consequi	ence or).							
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ğ	quire en sig uld b							1 □ Ye	s 2 No	3 □ Pro	obably 4X Uni	known
ecord	law re as bee 2 sho	Set						24a. Was ar	24b.	Were au	topsy findings av	ailable
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5	Physician: r this certific ral director,	0 B	examiner? 1 ☐ Yes 2 ▼ No Hospital: 1	□Inpatient 2□E	ER/Outpatier	nt 3□ DOA Oth	ler: 4 ☐ Nursing H	ome 5 🗆 Reside	ence 6 📆 Otl	ner (Spec	ify) HOSPI	CE
0	ding Phys I. After this funeral di	핕		ate of Injury Month, Day Year)	28b. Time o	f 28c. Inju Wo		28d. Describe ho				
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5	tal or A s after al Direc ed in by	Cer										
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only 2 Legativing Physician: To	the best of my know	wledge, deat	h occurred at the ti	me, date and place	, and due to the carred at the time. d	ause(s) and mate and place.	anner as and due	stated. to the cause(s)	
	To the H within 24 To the Fi complete	edical	one) and r	nanner stated.								
	Vit To	Σ	29b. Signature and title of certifier	Res)		29c. Licens	se number		9d. Date signe			
	V					2/			- 26		-/'	
1	0		30. Name and address of person who completed	cause of death (item	23a) (Type,	Print)						
			DR. EDDIE NAKHUDA 230	O DULANEY	VALLE	TY RD. T	IMONIUM,	MD 21093				
		ate	31. Date filed (Month, Day, Year) 1 2007	2. Registrar's Signat	ture d	Carles .						
	Regist	rar	AUG U Z COOT	The same								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 29°, 200°7° 1:45pm м Richard Joseph Driscoll /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Carroll Hospice Dove House Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day Ye Oct. 28, 6. Sex Birthplace (State or Foreign County)

A **Funeral** 1922 Days Hours Min. **X**X M 2□ F 022-12-5074 84 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4149 Salem Bottom Road 21157 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ante of Health and Mental Hygiene. and the than "natural", or ite arms the file marked other than "natural", or ite any or other traumatic event, the Medical Examine any 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 1 No WWII Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President of Bank Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Driscoll Leona Markley မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Gloria M. Driscoll (Spouse) 4149 Salem Bottom Road Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) All County Cremation 8/1/2007 Sykesville, MD 21. Signature of Funeral Service Licenses HAIGHI FUNERAL HOME & CHAPEL, P.A. (Sykesville, MD 21784 (410)-795-1400 MOOX4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lati disease or condition resulting in death) /Medical ysturction Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of dause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy perform certificate 40 venti 1∐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home HOSPICE Certification: To 5 Residence 6 Other (Specify) 27. Manner of Death
i Natural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation NIA 1 ☐ Yes 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician:

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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andano egistrar's Signature

and manner stated.

MD

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) ≥Year ≥007 45 **Physician** CCA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 0 N/A BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 CXF Yrs. GEORGIA FEB 22 1941 66 **Director** 219-40-7349 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State show r 28a-f show notified at 1. Yes 2 No Director MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be U.S.A. 124 W. FRANKLIN STREET APT 302 21231 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify: BLACK ð 3 ☐ Widowed 4 X Divorced natural" Completed I Hygiene. other than "natur ent, the Medical I 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTICE ENGINEER SELF 12th grade d other t event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) / Health and Merical Item 27 is marked of Be MARY PROSSER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 9311 Migan Rd., Randallstown, Department of Health Important: If item 27 any injury or other troonce. MD., 21133 William E. Edwards/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ Removal from State 08-04-07 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) KING MEMORIAL PARK 21. Signatur of Funer ervice Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ~NGEST/ VE /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 mor 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

9

State Registrar 30. Name and address of rerson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

18 SEPM

ST. PAUL Registrar's Signature

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per dr., g870, 08/01/07/hb Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Lee Davis Rosie **Physician** Ile 2007 /Medical 4b. City, Town, or Location of Death 4a. Façility Name (If not institution, 4c. County of Death **Examiner** MOU ral (If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Min Months 1 □ M 2 🔀 F 240-44-3700 30 Director Voryh Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritai Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Decunation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. achine C 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental -noch Foreman 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: If item 27 is any Injury or other trau Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M Burial 2 ☐ Cremation permit. Page Department of 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 0136 rd. OL 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner physician and s the burial-transil or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy nerformer 1∐ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25/No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation death. 2 Accident 1 Tes 2. after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title-of certifier

State Registrar

31. Date filed (Month, Day, Year) AUG

3₽ Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 30 AM Demor 27 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give_street and number) 4b. City, Town, or Location of Death Examiner Ka Balhmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Months 1 M 2 F Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. OO NOT use retired). 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughte Baltimore, 20a. Method of Disposition City or Town, State 1 Surial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Bathmac Md 21229 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cholangiocarcinoma **Physician** 4 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Be Completed by 2 should be Diabetes 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes has been Hupertensim 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page certificate 1□ Yes 2☑No or Attending Physician; funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled the Hospital 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I am MD DS1783

Registrar

2411 W. Belvedere Are

Baltmae

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MID

Tarmin

31. Date filed (Month, Day, Year) AUG 0 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 2007 26 6:45 A M ALBERT JOSEPH DISETA 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6 Sex Months Days Hours 1**X** M 2 □ F Mar. 19, 1916 Maryland 91 217-07-0841 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Bel Air Harford 10g. Citizen of What Country? 10e. Street and Number USA 21015 1227 Marston Court 12. Was Decedent Ever in U.S. Armed Forces? 1★1 Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WII White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturer Welder 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fannie (nmn) Barone Phillip (nmn) DiSeta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1227 Marston Court, Bel Air, Maryland 21015 Phyllis J. Grymes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 7-28-07 Baltimore, Maryland Sacred Heart of Jesus 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Fineral Service Licenses 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or - a consequence of): carlion Sequentially list conditions, if any, leading to immediate caus. Entar Uncerying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify)

Examiner requires that the death certificate be executed and the burial-tra Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical s been signed by the s has le 2 page this After thi or Attending 24 hours after death. Funeral Director: A stely filled in by the fu death.

Completed by

Medical Certification: To Be

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

the Medical

Director

Funeral

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death with

2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other It any injury or other traumatic event, the once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

9 Unknown	3D 5/1/4/04/11	
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣️☐Unknown
neval fuln		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical	26. Place of Death	Check onl one
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Hor	ne 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number

532255

Ju)421,204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014

State Registrar

32. Segistrar's Signature 31. Date filed (Month, Day, Year) AUG 0 1 2007



within 24

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1 - For State Registrar	State of Marylar	nd / Depa		ealth and I	Mental Hy	giene Reg. No. 2007	24560
		1. Decedent's Name (First, Middle, Last,)				2. Date of Dea	ath	3. Time of Death
	Physician	William Gale	Dunissant				July 29	Day Year 2007	11:15 A ^M
	/Medical Examiner	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	
	Zammer	2953 Dublin Ro	he		Street			Harford	
	Funeral	Social Security Number 6. Sec.	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt. (Month, Day		thplace (State or Foreign
	Director	229-42-1928	%™ ² □ F 73	Yrs.	Months Days	Hours Min.			th Carolina
	pu 🛊	Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or Lo	nation		- 1002		10d Incide City Limits
1_	the Marylar 28a-f ehow notified at		100. 01	ly, rown or Lor	ation				10d. Inside City Limits 1 ☐ Yes 25 No
2	with the Mar	Maryland Harford 10e. Street and Number	St	reet	10/ 7/ 0-1-			10-07-1-1111	
Chirat 6	death with the Maryland me 23a or 28a-f ehow trinial be notified at				10f. Zip Code			10g. Citizen of What Co	ountry?
<u> </u>	r Item 234	2953 Dublin Road	12. Was Decedent Ever in U	S 13 V	21154	spanic Origin? (S)	necify Yes or No.	USA 14. Race - Ame	arican Indian
7	riter d	1 ☐ Never Married 2 ☑ Married	Armed Forces?	lf	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Whi	
$\Im \mathcal{E}$	er, o	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	White
5-0036	ed within 72 hours atter ygiene. ner then "neturel", or Ite t, the M. dical Exporter Completed by Fui	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occupa	tion	kin a	16b. Kind of Business	
72	e. nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. C	kind of work done do OO NOT use retired)	uning most of work	King		
√ 2	Hygien the out, the out, the	11		Antiqu	e Car Ref			Self Emplo	yed
길	be filed within 72 hours atter death with the Maryla nial Hygiene. Indicate then "neturel", or Iteme 23a or 28a-f ehovevent, the Medical Examiner most be notified at Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, the M. To Be Compl	Fielder Ray Dun			,	Mary El.			
Maryland	2 sh and Iem	19a. Informant's Name/Relationship (Ty						r, City or Town, State,	
	s 1 and 2 should f Health and Mer item 27 le marke other treumatic	F. Maxine Duniva		-	C/ C - C - C - C - C - C - C - C - C - C			yland 2115	
以が//ra.rr Baltimore,	0 0 = =	20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ F	iemovai nom State		sition (Name of natory or other place	1	Date	20c. Location - City or	Town, State
)//	permit. Pag Depertment Important: I eny Injury o	4 Donation 5 Other (Specify)			lemorial (Bel Air, M	aryland
≥ Bal	permit. Depertr Importe eny Inju	21. Signature of Funeral Service Licens	7.		Name and Address ICCOMAS FU				
		23a Parti File the disease or compl	ications that assessed the deat	b Do not onto	317 Cokes	sbury Ro	ad, Abin	gdon, Mary	land 21009 Approximate
		23a. Part1. Enfer the disease, or compleshock, or heart failure. List only of Immediate Cause (Final							Interval Between Onset and Death
	Physician /Medical	disease or condition resulting in death)	ALZHE!		DISEAS	E, END	STAGE		
	Examiner		Due to (or as a conseq	uence of):					
	i i	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
	uted ansit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć.	be executed sicien and burial-transit	resulting in death) Last	Due to (or as a conseq	uence of):					
760,	e be sicie e bui		1						
89									
Вох	es that the death certifica igned by the attending ph be detached for use as it by Physician/Med	230. Was decedent pregnant	3c. If yes, outcome of pregna		Ectopic pregnancy			23d. Date of de	livery
	death	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of d		Other (specify)			Month	Day Year
P.O	that the de ned by the a detached to	9 ☐ Unknown							
	signed d be de	Part If. Other significant conditions cor			derlying cause give	n in Part I.		bacco use contribute to	20120
ord	: The law require cate hes been si , page 2 should b	CORONARY AK	TERY DISEA	SE			1 🗆 Y	es 2 □ No 3 □ P	robably 4 Unknown
e S	law es b a 2 st						24a. Was a	an 24b. Were at	utopsy findings available completion of cause of
<u> </u>	sician: The law certificate hes b irector, page 2 s						perfor	med? death?	2□ No
/ita	clan: entific ector,	25. Was case referred to medical examiner?				26. Place of Dea	th Check only or	пе	
Ę,	hysi this o al dire	10163 20010	lospital: 1 Inpatient 2			4 Nursing H		ence 6 □Other (Spe	cify)
L C	r Attending Physic or death. ector: Alter this ce by the funeral dire- tiffcation; To E	27. Manner of Death 1 ÆNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occurred	
Sic	tend death tor: the t	2 Accident investigation 3 Suicide 6 Could not be	Discouling the second			es 2 □No			
Division of Vital Records,	tel or Attending P rs efter death. el Director: After l ed in by the tunera Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre y)	et, factory, office		City or Tow	treet and Number or Ri n, State)	ural Route Number,
		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge dest	populated at the st	o data and the	and due to the	nauco(a)	
	the Hosp thin 24 hou the Fune mpletely fil	(Check only 2 Medical Exemit	ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my opi	e, date and place, inion, death occur	red at the time, o	ause(s) and manner as late and place, and due	s stated. to the cause(s)
	omple	29b. Signature and title of ceptifier	Z. Z		29c. License	number		29d. Date signed (Mont	h, Day, Year)
	->-0	Mudlia	The HO		2/15	7 //			
	27	30. Name and address of person who co	/	23a) /Type - 5		344		07/30/2	00 7
	8		A.I.		•	S DE 111.	CE MA	21078	
	State	SURESH DHANTAN; 31. Date filed (Month, Day, Year) AUG 0 1 2	32. Riegistrar's Signa	ture	1117776	JIL CKM	1	21010	
	Registrar	AUG 0 1 2	JU7 Statista	St. A.	asti i				

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Robert Benjamin Davis July 26 2007 2:16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 12801 Old Columbia Pike, Apt.221 Silver Spring
If Under 1 Year | If Under 24 Hrs Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours **½**M 2□ F Director 228-16-2679 July 11, 1922 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? Items 23a 12801 Old Columbia Pike, Apt. 221 20904 permit. Pages 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Washington Star Elementary/Secondary (0-12) College (1-4or 5+) Route Manager Newspaper 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernie Davis ည Minnie Guthrie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type. Print) Barry Davis, Sr. /Son 12801 Old Columbia Pike, #221, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State 4 □ Donation 5 □ Other (Specify) Aug 10, 07 Roanoke, Virginia Fair View Cemetery 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer of Colon /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease, Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Hypertension, Chronic Obstruction by Disease 24a. Was an autopsy perform certificate 1∐ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred (Month, Day 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

hours after death.

Ineral Director: After this
y filled in by the funeral di within 24 hours a To the Funeral L

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

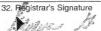
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Natasha Laming-Lee 1160 Varnum Street, NE Washington, DC

Registrar

Medical

31. Date filed (Month, Day, Year) AUG 0



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla State Amend #10a-f Per FH G	874 Pepa 874 Pepa	atment of H tificate of	lealth and Me Death	ental Hygi	iene	07	24	562
		1. Decedent's Name (First, Middle, Last) 2. Date of Death							Year	3. Time of I	Death
	Physicia /Medic		Clara Sme	chna Du	bbs	Maria	July 27		rear	5:54	P M
ž.	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						f Death		
			Gilchrist Hospice	Towson			Baltir				
ľ	Funeral Director		5. Social Security Number 408-54-3063 6. Sex 1 □ M 2 ▼ F 80	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Aug 18,	Year)	9. Birthpl Count Ukra		Foreign
	D	l Director	Usual Residence of Decedent								
36	arylar show d at		To Descripted	City, Town or Lo		ome Decel			16	od. Inside City 1 ☐ Yes	
	the M 28a-f otifie		TID - HOWALE	aurel		ano Beach	14	Da. Citizen of Wi	hat Count		P
	with a or t be r		10e. Street and Number 4030 W. Palm Aire I	II. #203	20723	33069-000	n	U.S.A.	iac oourii	.,,.	
	leath	Funeral	11 Marital Status 12. Was Decedent Ever in	U.S. 13. 1		Hispanic Origin? (Spectan, Mexican, Puerto F		14. Race	- America	an Indian,	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be Completed by Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 □ Yes 2⊠ No		ićan, etc.)	Black Specify:	, White, e		
8	hour tural		15. Decedent's Education	16a, Decer	dent's Usual Occur	pation	1	16b. Kind of Bus			
Maryland 21215-0036	rithin 72 ne. han "na e Medic		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	kind of work done DO NOT use retire	during most of working	g			 ,	
2	led w Hygie her tl nt, th		17. Father's Name (First, Middle, Last)	Home	maker	18. Mother's Name	(First Middle A	Own Hor			
anc	d be f intal h ed of		Dimitri Smechnoi			Vasilisa			'/		
Ž	should be filed and Mental Hygi Is marked other aumatic event, t		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rural			State. Zip	 Code)	
<u>8</u>	nd 2 suith ar		Diane Salvatore /daughter			imbers Ct.		•		•	
ē,	s 1 and 2 if Health Item 27 I		20a. Method of Disposition 20l	b. Place of Dispo		; Da		20c. Location - C			
Ë	Pages nent of I int: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Nat. Ce	i i	. 07	Arlingt	on.	Virgin	ia
Baltimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature Funeral Service Livense	22	2. Name and Addre			- A -	122211		
	20 E # 9			773	313 Talbo	ott Ave. La	aurel, 1	Maryland	207		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								ween
		Examiner	resulting in death) Due to (or as a cons	/					1		
			Sequentially list conditions, b. District or as a pursuagrands of						-		
			Sequentially list conditions, if any, teaming to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
,	execunand and al-tra	xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):								
8760,	cate be executed physician and the burial-transit	Physician/Medical I	d d								
9	rtifical ng phy as th										
Box	ith cer tendir r use		230. Was decedent pregnant						23d. Date of delivery Month Day Year		
P.O. E	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	ysici	in the past 12 months? 1 ☐ Yes 2 Z No 9 ☐ Unknown	of death 5 ☐	Other (specify)			NAIO	itti	Day	Cai
	s that I ned by s detail	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								eath?
or Vital Records,	w requires been sig should be	ed b	1 ☐ Yes 2 No 3 ☐ Probably								Jnknown
ecc	ne law re has be ge 2 sho	Be Completed					24a. Was a	sv D	Vere auto	psy findings a	available ause of
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Vita	ilcian: Th certificate ector, pag		25. Was case referred to medical examiner?		100	26. Place of Death	(Check only on			11000	
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Ö	ding I h. After funer	ion	27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Vortex Vork? 1 Accident investigation 28d. Describe how injury occurred Vork? 1 Yes 2 No								
Division	or Attending Physician; after death. Director: After this certifica in by the funeral director, i	Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 ★ ertifying Physician: To the best of my 2 Medical Examiner: On the basis of examand manner stated.								3)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. Licen	se number	_ 2	9d. Date signed	(Month,	Day, Year)	
	N		1000)Ln			64395		July	27,	2007	1
	10	Įij	30. Name and address of person who completed cause of death (DANIEUE DOBERMAN, MD 31. Date filled (Month Park Year) 32. Reflistrar's S	Item 23a) (Type,	Print)	NTOWN BE	VD, TO	WSON, A	10	2,204	
	Sta										
	Registi	ar	A LOUT A LOUT	1	Tonas D. D						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 30 2007 Denker 11:30 AM Maud R. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Manor Care - Rossville Rossville Baltimore 8. Date of Birth (Month, Day, Year) May 17,1915 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 1 □ M 2 🔀 F 92 212-48-4123 England Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Essex 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 105 Mace Avenue 21221 England 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia J. Bloom 202 Cove Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 3/07 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signatur 22. Name and Address of Facility 300 Mace Ave. Balto. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURS CONGESTIVE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 2ZNo 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA

/Medical Examiner be executed burial-transit physician requires that the death certificate the attending p for use as as been signed by the should be detached

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or ? must be n

7 is marked other than "natural", or iten traumatic event, the Medical Examiner

other t

= 5

permit. Page Department o Important: If any Injury or

Physician

Pages 1 and 2 should be filed within 72 hours and 1 Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", c

Maryland

Baltimore.

Box 68760.

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Division or Vital Records,

Director

Funeral

Completed by

Be

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MD

Physician/Medical Examiner

Completed by Be 2 27. Manner of Death

page 2 s director, After th funeral Certification:

certificate

this

or Attending

Medical

To the Hospital

State Registrar

PANICAT KHETORPAL 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a. Certifier

(Check

one

4 Homicide

201

28a. Date of Injury (Month, Day Year)

and manner stated.

M

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

09-203000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

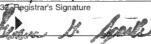
30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

RIVER NECK BD # 109 , BACK

5 Pending

investigation

6 ☐ Could not be determined



07-05823. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Elam State of Maryland / Department of Health and Mental Hygiene 24564 1- For State Certificate of Death Reg. No Registra 2. Date of Death Physician/ Decedent's Name (First_Middle.Last) Month Day July 30, 2007 Medical Examiner 0025 hrs 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Johns Hopkins Hospital **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Min 219-02-417 1 X M Country) 2 Usual Residence of Decedent 10a. State 10b. County Oc. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f shov , or items 23a or 28a-f shor r must be notified at once, Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code d Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, traumatic event, the Mrdit - Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes s, Give Yea Divorced Yes 2 No specify: Specify: If item 27 is marked other than "natural" þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Be 19b. Mailing Address 19a. Informant's Name/Relationship (Street and Number or Rural Route Number, City or Town, State, Zip \mathcal{A} 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State or other 1 Burial 2 Cremation tant: Donation 5 Other Specify 22. Name and Address of Facility Physil, P Signature of Funeral Service Licenses A. WEATHER FORD BA116 MD Z12 431 E. 01.LERST 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Seizure disorder xaminer or condition resulting in death) Due to (or as a consequence of): Remote head injury Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed e attending physician and for use as the burial - tran Physician/Medical X AMENDED line a-b, X UNPENDED 27,28a-f, perME,g871,9/19/07 TT The law requires that the death certificate be O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, P. Yes 2 ✓ No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✔ Yes 2 1 🗸 Yes No 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other; Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural To the Funeral Director: completely filled in by the Pending Yes 2X No within 24 hours after death. 6/29/1999 unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

15-1#-2UD

30. Name and address of person

Medical

State Registrar

31. Date filed (Month, Day, Year,

29b. Signature and title of certify

Jack Titus MD

Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 distrar's Signatur

who completed cause of death (Item 23a)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

July 30, 2007

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** GRAY DOROTHY 2007 12:07 PM 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A LEVINDALE GERIATRIC HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 3/22/1926 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 215-28-6101 1 □ M MARYLAND Director 81 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at BALTIMORE CITY N/A1 ∑Yes 2 ☐ No MD Director the 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? 2434 W. BELVEDERE AVENUE USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene. Austr if Hean Z7 Is marked other than "natural", or items 23, and it if the very the Medical Examiner must any or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify <u>۾</u> Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Bural Boute Number City of Town, State, Zip Code)

10 N. CALVERT ST, BALTIMORE, MD 21201 ARTIE SHAW/LEGAL GAURDIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once. 8/02/07 BALTIMORE, MD CARMEL CEM. 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Suneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Approximate Interval Between Onset and Death Efficient he direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. 23a. Part shop Immedi e use (Final disease condition resulting in death) ERMINAL DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Every class (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 █ No Month Day Year 4☐ Pregnant at time of death 9☐ Unknown signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an page 2 s autopsy performe certificate 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation after death. 1 🗌 Yes 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State

Registrar DHMH 17 Rev 1/2001 29b. Signature விறி title of certifier

BABAMME

HYSICIAN

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANI

A CARLO

Registrar's Signature

M

29c. License number

2434

D0064533

CHERLA

AVE

- MCBROW

W. BELVEDERE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend items 29c, 30, 31 per dvr 98/0 8-1-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** (sarmo) 27 2007 /Medical 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** andallsfour HOSP ita Bultimore Northwest If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛣 F Director 88 224-14-9647 July 6, 1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1x15x1Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2725 Walbrook Avenue 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygie 7 is marked other ti homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic ev George Holden Pearl Ball ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline Zagoria / Daughter 1639 Northwick Court; Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery 08/03/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** disea Sequentially list conditions, any country to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of): Box 68760. physician eq Physician/Medical the as attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. s been signed by the same should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page performe death? 1 ☐ Yes 2 ☐ No certificate PE No 1∐ Yes Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ANatural Injury 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide ō 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) MD 30. Name and address of who completed cause of death (Item 23a) (Type, Print) MD, Northwest Jessa Edelman 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend state of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Paulette July 21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 313 East Coldspring Lane Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕱 F Days Hours Min. 215 60 0624 56 Director Mar. 30, 1951 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, th. Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1X Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Chapelgate Road Apt. 3B 21229 LISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 20 €No Be Completed by Specify. Specify 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) school teacher Baltimore City Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Gibbs Pauline Holden ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Dorsey / Sister 313 East Coldspring Lane; Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem 07/31/2007 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. Jones 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician howel obstruction month /Medical Due to (or as a consequence of): **Examiner** caranoma 5 years a ppendiceal MUCINOUS Sequentially list conditions, any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home Thesidence 6 Nother (Specify) Sister's Certification: To 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Z Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 24, 2007 Warre mo D23809 Lustin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Cancer Ctr., 22 S. Greene St.,

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

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Doyle ms.

Greendou m 32. Segistrar's Signature

Bout., MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jane Graening 2007 or Location of Death 4c. County of Death harles C_{i} ata If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, May 29, 9. Birthplace (State or Foreign Days Min. ^Y932 West Virginia 1 ☐ M 2 🔀 F 75 578-42-6420 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Waldorf Maryland Charles 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12173 Gillespie Circle 20601 United States 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Clerical 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Rias William Snyder Lockhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10061 Deerfield Ct., Twinsburg, OH 44087 19a. Informant's Name/Relationship (Type. Print) Pamela Jean Boova/Daughter 20b. Place of Disposition (Name of Cemelery, crematory or other place) Geo Wash University Medical Center 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Ignature of Funeral Service License 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimoré, Maryland 21215-003

with the Maryland

burial-trans attending physician for use as the buria the a been signed by

Examiner Physician/Medical Be Completed by Certification: To

requires that the death certificate be executed To the Hospital or Atten Ing Physician: The law within 24 hours are death.

To the Funeral Lirector; After this certificate has b

Division or Vital Records, P.O. Box 68760,

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page 2	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ŭ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	23d. Date of delivery Month Day Year					
artii. Other signisteam conditions of	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown						
				24a. Was an autopsy performed? 1 Yes 2 ★			
25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
 27 Manner of Death 	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred		
1 ENatural 5 Pending investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factor	28f. Location (Street City or Town, Sta	. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying Ph	niner: On the best of my known in the basis of examination and manner stated.				r(s) and manner as stated. and place, and due to the cause(s)		
29b. Signature and title of certifier.	0.10	29	c. License number	29d. [Date signed (Month, Day, Year)		

State Registrar 31. Date filed (Month, Day, Year) AUG 0 1 2007

Mathur

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amend Items State of Maryland / Department of Health and Mental Hygiene dr., 28/0, 08/01/0/dhb

Reg. No.

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** JULY 5, 2007 9:15P Leonard (nmn) Grzanowski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 117 M 2□ F Director 80 368-20-0956 Michigan June 28, 1927 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r 28a-f sh notified 1 □Yes 2 No Director Maryland Harford **Edgewood** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 1818 Larch Drive 21040 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ould be filed within 72 hours after. Mental Hygiene. Armed Forces:

1XX Yes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No þ Specify. 3₺Widowed 4 Divorced White "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Medical Lab Manager U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank (nmn) Grzanowski Sr. 2 Mary (nmn) Kowalkoska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Grzanowski/Son 121 Goucher Way, Churchville, Maryland 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-10-07 <u>Air Memorial</u> Bel Air, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Charles a an 1317 Cokesbury Rd., Abingdon, Maryland 21009 nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only the Immediate Cause (Final **Physician** RESPIRATORY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CARDIOVASCULAR ARREST UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Upper Gastrointestinal bleeding physician and s the burial-tran-Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Anorexia, dyphagia, dehydration, hepatitis C, Completed dementia, diabetes mellitus type II 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate ha 2**X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending uspital.
4 hours after de...
...neral Director: Ahr 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 072692 JULY 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBORAH BULLOCK, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Records, P.O. Box 68760.

State Registrar

31. Date filed (Month, Day, Year)

K. Dana M.D. 3455. D6018362

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ORIGINAL

AVE. Suite LIO, Balto. Md21229

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27, 2w7 **Physician** 0:30PM DLTZMan Marie ulu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number), **Examiner** HOSPITAL Irs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Year) Months Min Days Hours 688 1 □ M 2 🗷 F 499-46-6884 Usual Residence of Decedent Director be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b: County NIA 1 Tryes 2 □ No Balte Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. white 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Hospitals Elementary/Secondary (0-12) FracticaL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HaLL ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fairway DR. Westminister 12 daughter , MD, 211-58 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State -31-0 Catons ville rematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 2 21. Signature of Funeral Service Licen .md. 21229 ran 23a. Part1. En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one cause on each line. Immedia → Couse (Final disease of indition resulting in death) Sepsis Physician 10 days /Medical Due to (or as a consequence of): Examiner ute 6 ronchoneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dus to for as a consequence of The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): physician IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 prioriths?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown cate has been signed! page 2 should be dete 23e. Did tohacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 2 ☐ No 2 □ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) examiner: 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled n by 4 Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 30. Name and advies of person who completed cause of death (Item 23a) (Type, Print) SEINEL MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) 900 CATONAVE BALTIMORE, AUG 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		artment of H rtificate of L			giene Reg. No.C	007	24572
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Edwerta Wilhelm		H	ughes		2. Date of De Month July	ath 19 Day	2007	3. Time of Death 23:50 M
	Examin	ier	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last)			4b. City, Town, or Location of Death Laurel If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		8. Date of Birl	Pri	4c. County of Death Prince Georges 9. Birthplace (State or Fore Country)	
	Director		579-16-3546 Usual Residence of Decedent 10a. State 10b. County	□ M 2k F 88	Yrs.			Feb. 8,			ington, D.C.
1215-0036	e Maryla 3a-f sho v tified at		Maryland Prince Ge		Laure						1 □xiYes 2 □ No
	h with th 3a or 28 st be no	al Directo	10e. Street and Number 9000 Briarcroft Lane #	307		10f. Zip Code	707		_	en of What Coo d States	
	e filed within 72 hours after death with the Maryland Hygiene. other than "natural" or items 23a or 28a-f show other than "natural" or items 23a or 28a-f show vent, the Medical Examiner must be notified at	To Be Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☑ No		ecify Yes or No Rican, etc.)	- 1	4. Race - Amer Black, White Specify: Blac	rican Indian, e, etc.
			15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life. I	dent's Usual Occupa kind of work done o DO NOT use retired Statist	during most of work ') -	ing		d of Business/l	ndustry
Maryland 21	be do		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle)					,	e, Maiden Surname)		
Mary	2 shou and M is mar raumat		19a. Informant's Name/Relationship (7	ype. Print)		ng Address (Street a	and Number or Rur	al Route Numb			(ip Code)
altimore, I			Karen Lee/Daughter 20a. Method of Disposition 1* Burial 2 Cremation 3 4 Donation, 5 Other (Specify	nemoval mom state	Place of Dispo cemetery, crer	Claxton Dri position (Name of matory or other place ational Mem	re)	Maryland Date -/2007	20c. Loc	el, Mary	
Balti	permit. Page Department of Important: If any injury or once.		21. Sig ture Funeral Service Licen	see Wha		2. Name and Addreseck Funeral	*	Sandy Spr	ing R	oad Laure	el, MD 20707
. Box 68760,	Physician and // // // // // // // // // // // // //		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Betwee Onset and Death MYOCARDIAL INFARCTION HOURS								Interval Between Onset and Death
		L	Sequentially list conditions,	equence of):					YEAR		
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Either underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence								
	The law requires that the death certificate be the has been signed by the attending physici age 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{ZNo} \) 9 \(\text{Unknown} \)	d23c. If yes, outcome pf pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	□Ectopic pregnancy			2:	3d. Date of deli Month	very Day Year
rds, P.O.	quires that t n signed by ald be detac	To Be Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 6								the cause of death?
Vital Hecords,						-				24b. Were au prior to d death? 1 □ Yes	topsy findings available completion of cause of
	yslcian: is certific director,		25. Was case referred to medical examiner?							□Other (Spec	cify)
ion or	Ing Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28b. Time of Injury	8b. Time of 28c. Injury at 28d. Descri			ribe how injury occurred			
DIVISION	tal or Atters after de al Directo	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: K completely filled in by the fi		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
1			29b. Signature and title of certifier			29c. License				signed (Month	
	3		30. Name and address of person who of Vincent D. Haye	completed cause of death (Ite	m 23a) (Type,	Print)	Emergi 1 7200 1/	ency De	pt.	Jan Jan), 2007 rel, MD 20707
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	ral Hospita. Araelle	1300 //	un Duser	1 110	, Lu	I DI WILLIAM TO I

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ORIGINAL

07-05737 Katherine Harp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

37 ine Harp		Please T	ype or Print in State of Marylar	id / Departm	nent of	n k. Ensure Health and Death	All Copie I Mental Hy	rgiene Reg.	L. U	07 2457
Physician al Examine	er er	i. Decedent's Name (First, Mi Kacherine Harp Ha. Facility Name (if not institute)	p	her)		4b. City, Town, or	ocation of Death	2. Date of Death Month D July 26, 200	year 17 4c. County of Dea	3. Time of Death 1220 hrs
Funeral	L	3107 Good Hope R	Road #211	. Age (In yrs. last bi		Temple Hills		8. Date of Birth	Prince Georg	ge's Birthplace (State or
Director	L	251-84-9619 Usual Residence of Decedent	1 M 2 X F	58	Yrs	Months Days	Hours Min.	Sept. 27	, 1948	eign Country) SC
nd show any nce,		10a. State 10b. Cour		10c. City, Tow	n or Loca	Baltimor	e			10d. Inside City Limits 1XX Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.		10e. Street and Number 3107 Goodhope A	Avenue; Apt. 21	1.		10f. Zip Code	20748	. 10g	. Citizen of What Co USA	
be filed within 72 hours after death with the Maryland ntal Hygeine. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at one	Funeral	11. Marital Status 1 X Never Married 2	A Tan	dent Ever in U.S. ces?	ja, Jf Y	as Decedent of His es, specify Cuban	, Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	erican Indian, Black,
Id be filed within 72 hours after death wi fental Hygiene. narked other than "natural", or items veent, the Medical Examiner must be	eted by	3 Widowed 4 15. Decedent's Education (S	Specify only highest grade		a. Decede	nt's Usual Occupat nost of working life	ion (Give kind of v DO NOT use reti	vork done red)	16b. Kind of Busines	s/Industry
Hygiene. d other than the Medic.	91	17. Father's Name (First, Mid		; - ' -		disal	oled 18.Mother's Name		n/a aiden Surname) n Fuller	
e a de	To Be	19a. Informant's Name/Relati Betty Jean Harp	tionship (Type, Pnnt)					Rural Route Numb	per, City or Town, St. Carolina 29	
Pages 1 and 2 shounent of Health and Niaut: If item 27 is roor other traumatic		20a. Method of Disposition **Burial 2 **XCrema 4 **Donation 5 **Othe		m State crem	natory or o	sition (Name of ce ther place) natory	08/0	Date 01/2007	20c. Location - City Baltimore.	Maryland
permit Departs Import Injury	1	21. Signature of Funeral Ser 23a. Part I. Enter the disease	James	used the death Do	1 6	38 North G	ilmor Stree	et; Baltim	Home, P.A. ore, Marylan	nd 21217 Approximate Interval
ysician Medical caminer	ļ	failure. List only one ca Immediate Cause (Final dise or condition resulting in deat	ause on e ch line. ease a. <mark>Atheroscler</mark> e	otic Cardiovaso						Between Onset and Death
ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiate events resulting in death). Li	euse c.	consequence of):			<u>Pa</u>			
e be executed ysician and burial - transi	edical	UNPENDED		TEM#20a,pe		370,8/1/07,	WS		23d. Date of deli	verv
eath certificate be ex attending physician for use as the burial	sician/I	IF FEMALE: 23b. Was decedent pregnant past 12 months? 1 Yes 2 No 9 ✓	t in the 1 Live bi	ant at time of death	2 F	Fetal death 3 Other (Specify)	Ectopic pregn	ancy	Month	Day Year
gned by the	by Phy	Part II. Other significant co			lting in the	underlying cause	given in Part I.			e to the cause of death? Probably 4 Unknown
ral or Attending Physiciant. The law requires that rs after death. al Director: After this certificate has been signed led in by the funeral director, page 2 should be detailed in by the funeral director.	Completed							24a. Was a autop: perfor 1 ✓ Yes	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 No
Physician; er this certi ral director	To Be	25. Was case referred to me examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 28a. Date		R/Outpatie	nt 3 DOA f Injury 28c. Inj	ury at Work?	ing Home 5	Residence 6 Conow injury occurred	ther: Scene
spital or Attendi tours after death. neral Director:	Certification:	2 Accident 3 Suicide 6	Pending Investigation Could not be determined (Specify)	e of Injury - At home	e, farm, st		Yes 2 No building, etc.	28f. Location (S or Town, S		r Rural Route Number, City
To the Hospit within 24 hour To the Funer completely fill	Medical Ce	29a. Certifier	ing Physician: To the best	of examination and	death occ	curred at the time, quation, in my opinion	date and place, an	nd due to the caus	e(s) and manner as and place, and due	stated. to the cause(s)
To vii	Me	29b. Sonature and title of d		M			se number		29d. Date signed July 27, 2007	(Month, Day, Year)
		30. Name and address of pe Susan Hogan MD	. Assistant Medic	al Examiner	111 Pe	enn Street, Ba	Itimore, MD 2	1201		
Sta Regist	ate rar	31. Date filed (Month, Day,)	Year) 2007 32 Re	egistrar's Signature	A DE	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year 7:05 AM Richard D. Hash, Sr. 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore, 132 Lariat Road
5. Social Security Number 6. Maryland Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 M 2 □ F 217-26-5683 83 02/25/1924 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 132 Lariat Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) School System Foreman - Concrete 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herschel Hash Bessie Halsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8413 Hallmark Circle - Baltimore, Maryland 21234 Marguerite Bollinger (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State 08/02/2007 Wouth of Wilson, 4 Donation 5 Dother (Specify) Youngs Chapel Cem. 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service License رمي 11750 Belair Road - Kingsville, Maryland 000 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Immediate Cause (Final CARDIOVASCUL AR disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead a vertex that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 □ Ectopic pregnancy Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Directo

Funeral

þ

Completed

Be

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, th. Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

I

Examine Physician/Medical Completed by

cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran certificate director, After this c funeral dire

Be

ဥ

Certification:

Medical

Records,

Division or Vital

or Attending

death.

within 24 hours after death

To the Funeral Director:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Probably 4 □Unknown 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy perform 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referre examiner?	
27. Manner of Death	
1 Natural	5 Pending

5 ☐ Pending investigation 2 Accident

6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

26. Place of Death (Check only one)

28d. Describe how injury occurred

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titl

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) 32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Wilma Jordan Harris 12:25 A M July 31, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 21, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 95 219-12-8497 1912 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Maryland Baltimore 1 ☐ Yes 2 🕅 No **Funeral Director** Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Rd. 21093 United States "natural", or Items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XX No Completed by Specify: 3X Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) <u>home</u>maker <u>own</u> home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental William E. Jordan Blanche Roberts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Harris/son 16620 Wesley Chapel Rd. Monkton, MD 21111 other t permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Green Mount Crematory Aug. 1,2007 | Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Rd. Baltimore, MD 2 21. Signature of Funeral Service Licensee John O. Mitchel at1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final tinal **Physician** houstoninte -2 hons disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, france, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: the death certificate be executed physician and ts the burial-tran Due to (or as a consequence of): Physician/Medical as ttending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heart failure 1 Yes 2 No 3 Probably 4 Unknown Completed AtoPor 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has e 2 autopsy page performe certificate 1∐ Yes 2 1 No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural within 24 hours after co-1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R-Motogs M.D D52197 07-31-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 6701 N. CHARLES ST. BALTIMORE, MD 21204 REKHA MOTAGI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** George John Irvin Hipple July 27. 2007 9:45 A M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Cherry Lane Nursing Center Prince George Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Months 1 M M 2 □ F Washington, DC Director 84 1923 577-22-9360 May 12, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 343 Marganza South 20724 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1⊠Yes 2□No If Yes, Give Year or Dates: 1943 -46 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer I.B.M. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Marshall Hipple Mary Zelma Satterwhit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Hipple /spouse 343 Marganza South, Laurel, Maryland 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk July 30,07 Dorsey, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 160 M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the of ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart foure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner General Debility Sequentially list conditions, if any, leading to immediate cause. Enter thousehing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-trans Dementia Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Dehydration certificate has page 2 autopsy Hypertension 2X No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0045217 30. Name and address of perso ho completed cause of death (Item 23a) (Type, Print) Dr. Ajayi 620**£** Greenbelt Road, #U15, College Park, MD 20740 31. Date filed (Month Pay 32 Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 2007 12:30 p^M 30, Charles Albert Hart July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1115 Berrymans Lane Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 30,1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ₹ M 2 □ F Director 215-44-1809 August Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene. and the file marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 Is anarked other than "natural", or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Funeral Director MD Baltimore Reisterstown 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 1115 Berrymans Lane 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Tailor Unitec 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Albert Hart Blanche M. Laws ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cerol A. Hart Wife 1115 Berrymans Lane, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Mem. Park 8/2/07 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** e 402 tor4 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

30, 2007

	-	For State	State of Maryl	•	rtment of F tificate of			000-	7 01 5 7
(94)		Registrar 1. Decedent's Name (First, Middle, Las	st)		incate or i	Death	2. Date of Dea		3. Time of Death
Physiciar /Medica	al .	ROSE MARIE J						27 2007	6:40A
Examine	er	4a. Facility Name (If not institution, give	ŕ			r Location of Death		4c. County of Dea	ith
-	4.	SINAI HOSPIT 5. Social Security Number 6. S		yrs. last birthday)	BALT'I If Under 1 Year	MORE C	9 Date of Birth	N/A 9. Bir	thplace (State or Foreig
Funeral Director			□M 21XF 80		Months Days	Hours Min.	(Month, Day 3/26/	r, Year) C	ountry) ARYLAND
D.	- 1	Usual Residence of Decedent							
show	.	10a. State 10b. County	100	c. City, Town or Loc					10d. Inside City Limi 1
Ba-f s) S	MD N/A		BA	LTIMORE	CITY			Λ
be filed within 72 hours after death with the Maryland ntal Hygiene. Indicate than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 4411 KATHLAND	AVENUE		10f. Zip Code	21207		10g. Citizen of What C USA	ountry?
deat	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Was Decedent of H	lispanic Origin? (S	pecify Yes or No- to Rican, etc.)	14. Race - Am- Black, Whi	
rs after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:	,		BLACK
thou atura	eq	15. Decedent's Ed	ducation		lent's Usual Occup			16b. Kind of Business	s/Industry
in "nat Medica	ble	(Specify only highest gra	College (1-4or 5+)	(Give life, L	kind of work done OO NOT use retire	during most of woi d)	rking		
d within giene. er than " the Mec	Completed	8			COOK			FOOD SE	ERVICE
be file d othe event,	Be	17. Father's Name (First, Middle, Last,)			18. Mother's Nar	me (First, Middle,	Maiden Surname)	
should be and Mental s marked o umatic ev	၉	JOSEPH FINLEY				BETS	Y FINL	EY	
2 shc and is ma		19a. Informant's Name/Relationship (**	1				er, City or Town, State,	. ,
and lealth m 27		ANDRE BRIGHT /	SON			AND AVEN	Date BA	LTIMORE,	
ë		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	a l	Ob. Place of Dispo cemetery, crer MARYLAN	natory or other pla	ce)		20c. Location - City o	
trmen tant:		4 Donation 5 □ Other (Specil	y)	MEMORIA	L PARK		13/07	LAUKEL,	MD
permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licer	nsee A. A.		Name and Address Name Address N	· F	HOWELL DEIGHTS	FUNERAL H AVE, BALT	OME 2120 IMORE, M
		23a. P. A. Enter the visease, or comshick, or earth filure. List only	plications that caused the						Approximate Interval Between
Physician		Immed at ause (Final				4			Onset and Death
/Medical		Immed at ause (Final diseas r condition resulting in death)	a. (ArdioT) Due to (or as a co		C E VEN	1			
Examiner			ASCVI	>.					
	ner	Sequentially list conditions, list y leading to in reactive cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):					
cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c						
e exe	Ĕ	resulting in death) Last	Due to (or as a co	nsequence of):					
ate b	dical		d						
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Med	IF FEMALE:	23c. If yes, outcome pf p	ragnonav					
attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □	Fetal death 3	Ectopic pregnanc Other (specify)	°y		23d. Date of do Month	elivery Day Year
the de	ysic	1 ☐ Yes 2 12 No 9 ☐ Unknown	9☐Unknown	e or death 5L	_Other (specify) _				
w requires that the de been signed by the should be detached		Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
uires I sign Id be	d b						1 🗆 🗅	/es 2 No 3 I	Probably 4 □Unkno
w req	ete						24a. Was	an 24b. Were	autopsy findings availa
he lav	Completed						autor perfo	rmed? death?	autopsy findings availa completion of cause
sician: The la certificate ha irector, page 2		25. Was case referred to medical	L			26 Place of Do	1 Yes ath (Check only o	2 1 Ye	es 2 No
Physician: r this certifice ral director, p	o Be	examiner?	Hospital: 1 Inpatient	2 ☐ ER/Outpatier	nt 3□ DOA Oti	hor:		dence 6 □Other (Sp	aggifu)
ding Phys h. After this funeral di	٦: ٦	27. Manner of Death	28a. Date of Injury	28b. Time o				now injury occurred	iscny)
Attending r death. ector: Afiel by the fune	tio	1 Matural 5 Pending 2 Accident investigatio	(Month, Day Ye	ear) Injury		rk?]Yes 2 □ No			
l or Attend a er death birector: /	ertification:	3 ☐ Suicide 6 ☐ Could not be determined		At home, farm, str	reet, factory, office		28f. Location (S City or Tox	Street and Number or i	Rural Route Number,
sa er sa er al bire ed n b	Cert	T	building, cto. (c	pouny)			Only or rov	m, otato)	
hour hour ner y fills			hysician: To the best of m	amination and/or in					
Fu Fu	<u>=</u>		and manner stated		29c. Licen	se number		29d. Date signed (Mo.	nth, Day, Year)
o the Hc ithin 24 o the Fu	Medical	29b. Signature and title of certifien						- ,	
on time	Medic	29b. Signature and title of certifier	M.D.		Do	0057 4	6>	7/3110	77.
To the Ho within 24 to To the Fu completely	Medic	▶ makijapahse		(Itom 22a) (Time					77.
/	Medic	2 1/	completed cause of death	n (Item 23a) (Type, 35 SmiM					77.

07-05 John

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		I- For State			Cert	ificate	of Death			Reg. No			of Death
Physicia		Registrar 1. Decedent's Name	e (First, Middle,La	st)					Mor		Year	171:	2 hrs
Exami		.Johr	n Patric	Jester	Sr		4h City Tow	n, or Location of I			c. County of	Death	
		4a. Facility Name (i		ve street and nur	nber)		Georget				Cecil		
				es.	7. Age (In yrs. la	st birthday) If Under 1	Year If Under	24Hrs. 8. Da	ate of Birth(MI	M/DD/YYYY)	9. Birthplace (
Funeral		5. Social Security N					Months Yrs.	Oays Hours	Min.	2/09/1	024	Country)Pa	a]
Director		182-	26 8602 15	M 2 F	72		113.			2/09/1	934		
any:		Usual Residence of 10a, State	10b. County		10c. City,	Town or Lo	ocation						side City Limits
<u> </u>		Pa	Montgor	nerv	FO	rt Wa	shingto	n				1. 21	Yes 2 No
nyland n-f sh t onc	ctor	10e. Street and Nu		ICL y		1. 0 1914	10f. Zip Co			109.0	Citizen of Wha	at Country?	
death with the Maryland or items 23a or 28a-f show must he notified at once,	Director	1120	Dames De				19	034	4 1		USA		
vith the s 23a	밀	11. Marital Status	Donna Di	12. Was Dec	edent Ever in U	.S. 13	Was Decedent	of Hispanic Origi Cuban, Mexican,	n? (Specify `Puerto Rican	Yes or No- , etc.)	14. Race White	- American Indi , etc.	an, Black,
eath v item ust b	uneral	1 Never Marr	ied 2 X Marrie	Armed Fo			ii res, specity				Constitu	White	11 11 41 11
fter d		3 Widowed		1X Yes or Dates:			Yes 2X	No specify: ccupation (Give k	ind of work d	one : 16		siness/Industry	
ours a	d by	15. Decedent's E	Education (Specify			16a. Dec duri	edent's Usual Or ng most of worki	ng life. OO NOT u	use retired)	one ro	pa v. s		
6 72 h cal E	lete	Elementary/Sec	condary (0-12)	College (1-4 or 5+)	- ·	c	۰۰ ۵۵			Commer	cial D	oor
5-0036 Hed within 72 hours after Hygiene. d other thau "natural", the Medical Examiner	Completed		(Class Middle Lo	44		Chie	i Execu	tive Off	s Name (Firs	t, Middle, Maid			
215-0036 be filed within 72 hours after death with the Maryland hall Hygiene. They other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	ျပ္	1						Ellen	B Kel	lv .			
2121 uld be fil Mental F mairked c event, i	o Be	George 19a Informant's N	ge H. Jes Name/Relationship	(Type, Print)		19b. N	Mailing Address	(Street and Num	ber or Rural	Route Number	r, City or Tow	n, State, Zip Co	ode)
Baltimore, MD 21 permit Pages I and 2 should Department of Health and Me Important: If item 27 is mail injury or other traumatic ey	F		ne M. Jes		fo	1113	0 Donna	Dr. For	t Wash	nington	Pa 19	9034	State
e, M I and 2 Health item 2		20a Method of D	isposition		20b.	Place of L	isposition (Name or other place)	e of cemetery,	Dat	e 2	Oc. Location	- City or Town,	State
altimore rmit Pages 1 a spartment of H uportant: If it jury or other t			Cremation		rom State		nn Neuma	an Com	8/01	/2007	Chal	font Pa	
Baltim permit Pa Departmen Important		4 Donation	5 Other Spec	eify: censee	50	. 00	22. Name and	Address of Facility	y	1 200 1-		13	
Balt permit Depart Impor		. V.	· 1/1/	.0	M0023	1	Ciavare	elli FH 9	951 E.	Butler	Pike	Ambler	roximate Interval
ysiciar		23a. Part I. Enter	the disease, or co	mplications that	caused the deat	h. Do not e	enter the mode of	f dying, such as c	cardiac or res	piratory arrest	, shock, or ne	Bei	ween Onset and Death
Medica		failure. List Immediate Caus	only one cause or	a. Drowning									Death
Examine	r	or condition resu	lting in death)		a consequence	of):							
		Sequentially list	conditions,	b		of):							
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exe an an	- 11all - 2	UNPEND	ED	AMENDE							23d. Date	of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execution after death.	ched for use as the burdal	IF FEMALE:	ent pregnant in the	23c. If ye	s, outcome of pr		Fetal death	3 Ectop	oic pregnancy		Month	Day	Year
687 ertific	e as t	past 12 mor	ent pregnant in the hths?		e birth gnant at time of	death 5	Other (Spe						
Box e death c the atten	tor us	1 Yes 2	No 9 Unkr	9 011	known								oung of death?
ires that the de	iched		gnificant condition	ons contributing	g to death but no	t resulting	in the underlying	g cause given in F	Part I.			ntribute to the o	4 Unknown
P.O.	e det	Hyperte	nsive Atheros	clerotic Card	iovascular D	isease							y findings available
rds, require	onld	Completed								24a. Was a autops	у	prior to comp	letion of cause of
Records, The law requir	e 2 sh	<u> </u>								perform		death? 1 ✓ Yes	2 No
tal Rec	bag'.	5	eferred to medical					26.Place of Deat	th (Check onl				
ital ician: s certi		examiner?		Hospital:	Inpatient 2	ER/Ou	tpatient 3	DOA Other	Nursing h	Home 5 F	Residence 6	Other: So	ene
Division of Vital rad or Attending Physician: rs after death.	ভ	1 ✓ Yes 27. Manner of I	2 No Death	28a. D	ate of Injury	28b. 7	ime of Injury	28c. Injury at Wo		d. Describe h		urred	
n of ding Ph h.		1 Natura			onth, Day,Year) ND:	FOU 1712		1 Yes 2	✓ No				
SiO Atter r deat	by th	1 Natural 2 Accide 3 Suicide 4 Homici		28e F	6, 2007 Place of Injury - A	At home, fa	rm, street, factor	ry, office building,		Taura C	(oto)		Route Number, City
Divi	ed in	3 Suicide	deter		ify) River					50 Skipjack I	ane, Georg	ge Town, Md.	
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	dy fil			nysician: To the	best of my know	vledge, dea	ath occurred at the	ne time, date and	place, and di	ue to the caus	e(s) and man	iner as stated.	ause(s)
the hin 2, the F	nplete	(Check only one) 2	Certifying Pl	miner:On the ba	sis of examination	on and/or i	rvestigation, in i	ny opinion, death	00001100 011	ne time, date		igned (Month,	Day Year)
T _o	CO	29a Signatur	and title of certific		1		2	9c. License numb	per		i		Day, reary
d	/	W.	/ XXL	1/1	7			O.C.M.E.			July 27,		
7		30. Name and	address of person	who completed	cause of death	Item 23a)			145 646	04			
20			logan MD.	Assistant Me	edical Exami	ner 1	11 Penn Stre	eet, Baltimore	e, MD 212				
4	Sta	ate 31. Date filed	(Month, Day, Year)	2007	Registrar's Sig	nature	house						
Re	gist		AUG U J	TOO1	Magasa		1						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2007 4:20 P Jean Elizabeth Jozwiak Ju₁y 30, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12916 Harford Road Hydes Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Yrs. Director 218-18-9284 82 1, 1925 Maryland Jan. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v Funeral 8663 Castlemill Circle U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Moving and Storage and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Harry Charles McCord Anna Eyre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Robert Eugene McCord (Brother) 12916 Harford Road, Hydes, Maryland 21082 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 tment of F 20c. Location - City or Town, State Department of Important; If It any Injury or o Wheat Ridge, Colorado 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify)Entombment Crown Hill Cemetery 08/06/2007 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licenses 9705 Belair Road, Baltimore, Maryland 21236 Approximate Interval Between Anset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ardiac or respiratory arrest, shock, or heart failure. List only one cause and ach line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of certificate be executed burial-trar and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. ģ cate has been si page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1□ Yes 2 1 No funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Brother's 26 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. After Division (Month, Day Year) Injury 1 U Natural 5 Pending 1 □ Yes 2 □ No investigation Director; / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D completely filled i Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 1 2007 0 AUG

29b. Signature



29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29c per dyr 987–8-1-07 yt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Pay Physician July 2007 3:30 pm Keith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Laurel Laurel Regional Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 6, 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) 1921 Hours Pennsylvania 1 X M 2 □ F Director 252-767-5779 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 L Yes 2 No Directo Laurel Anne Arundal Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20724 United States America Funeral 8366 Finchleigh Street 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dairy Milkman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Seltzer Clifton Keith မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8366 Finchleigh Street Laurel, Maryland 20724 Carole Holmes / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Palermo, New Jersey 7/22/2007 Seaside Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun al Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LYMPHOCYTIC PLEURAL EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of/ Examiner or Attending Physician: The law requires that the death cartificate be executed and use as the burial-tra Due to (or as a consequence of): P.O. Box 68760, ttending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by ACUTE ON CHRONIC RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown page 2 should CARDIOMYOPATHY 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC OBSTRUCTIVE PULMONARY DISEASE Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 64986 29b. Signature and title of certif MI

3

State State Registrar

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AttG 0 1 2007



10724 LITTLE PATUXENT PARKWAY, SUITE 200 COLUMBIA, MD 21044

22,2007

			For State Registrar	State of Ma	ryland	/ Depa	artment		ılth ar	nd Menta		ne 007	24582
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, 4a. Facility Name (If not institution, MOMOV (2007)	give street and number)	od	1 J	4b. City,	Town, or Loc	cation of I	JUL	of Death th	Day The Year 200 4c. County of Dea	3. Time of Death 11:20 A ^M th
	Funeral Director				(In yrs. la.	st birthday) Yrs.	If Under Months		Under 24 lours	Hrs. 8. Date (Mor	of Birth oth, Day, Ye	9. Bin	thplace (State or Foreign buntry)
	ith the Marylend or 28a-f chow	Director	Maryland Harford 10e. Street and Number	ā.		Town or Lo		Code			10g.	Citizen of What Co	10d. Inside City Limits 1 Tyes 2 Tho
9036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Heelth and Mental Hyglene. Depertment of Heelth and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show many highly or other treumatic event, the Medical Examiner must be mailfied at pine.	d by Funeral Director	807 Gail Cour 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?		1			nic Origir Mexican, F	n? (Specify Yes Puerto Rican, e	or No-	14. Race - Ame Black, White Specify:	
21215-0036	filed within 72 h Hygiene. kher then "natu int, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5-	+)	(Give	kind of wor DO NOT us	Il Occupation of done during the retired)		of working		. Kind of Business Lverware	/Industry
Maryland	should be fill and Mental Hy marked oth urmatic event	To Be	17. Father's Name (First, Middle, La William Hobar 19a. Informant's Name/Relationship	t Koch, Sr.		19b. Maili	ng Address	M	lary	s Name (First, 1 Blanche or Rural Route	Trac		Zip Code)
Baltimore, M	Pages 1 end 2 ent of Heelth ant: If Item 27 i y or other tre		William H. Koch 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State	cer	ce of Dispo netery, crea	sition (Nam natory or ot	ne of ther place)		Date	200	eryland 2. Location - City or	Town, State
Baltin	permit. P Depertment importarian any injur		21. Signature Juneral Sarvice Li	censee May 4		2	Name and MCCOM	Address of S Fun Cokesb	era1 ury	Home, Road, A	P.A. bingo		land 21009
	Physician /Medical Examiner		23a. Part1. Ent. the disease, or consock, or consock, or chart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a	e. BA I conseque	RDV Inco of): TR		ul				MBOSI	Approximate Interval Between Onset and Death Mohlus
8760,	icate be executed physician end sthe burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d.									
P.O. Box 68	ne death certif the attending thed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at to 19 □ Unknown	2 Fetal c	leath 3	Ectopic pre					23d. Date of de Month	livery Day Year
Records, P.	w requires thet the bean signed by should be detact	by	Part II. Other significant condition Myeloud		t not result	-	nderlying ca	ause given in	Part I.	_	1 ☐ Yes	2 No 3 P	the cause of death?
Vital Rec	ding Physicien: The lav h. After this certificete has funeral director, page 2	Be Completed	25. Was case referred to medical examiner?					-	. Place of	- _	. Was an autopsy performed Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	prior to death?	utopsy findings available completion of cause of
Division of \	I or Attending Physi after death. Director: After this c I in by the funeral dire	Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	t be	Year) 2	R/Outpatier t8b. Time o Injury	M 28	Bc. Injury at Work? 1 Yes	4 Vursi	28d. Des	scribe how i	e 6 Other (Spe injury occurred	
Ω	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:	Medical Cer	one)	Physician: To the best of caminer: On the basis of and manner state	f my knowi	edge, deat on and/or in	n occurred a vestigation,	at the time, of in my opinion	date and pon, death	place and due	to the caus	e(s) and manner as	s stated. to the cause(s)
)	To som	M	29b. Signature applies of certifier 30. Name and address of person wi	no completed cause of de	eath (Item 2	23a) (Type.	0	License nu	mber 0012	-849	29d.	7-30	
1			A. Hamid Ghilad	i, 7600 Osle	er Dr	., To		Maryl	and	21204			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1	2007 32, segistra			all)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 410 M 2007 dWar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 24, 1956 onns ins 10) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Yrs. Florida 464-08-2624 50 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director Pa. York York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17404 LISA 1899 Bradywine Lane Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates:1 986-2001 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alma Μ. Sanders Hubert L. Loch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) York, Pa. 17404 1899 Bradywine Lane Frances E. Loch / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/15/07 Arlington, Va. 4 Donation 5 Dother (Specify) Arlington National 21. Signature of Funeral end cense 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Weck /Medical Due to (or as a consequence of) Examiner 09 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transi 9 Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician a adenocarcinoma Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by ac No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 4 ☑ No 24a. Was an certificate has birector, page 2 s autopsy funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To Date of Injury 27. Manner of Death 1 XI Natural 2 Accident 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours after To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

0 AUG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Charlene A. Luber Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 25, 2007 1025 hrs Charlene Ann Luber Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University of Maryland Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Min. Months Days Hours Country) Director Oct 17, 1 M 2 X F 1961 MD 214-84-2821 45 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No MD Prince George Laurel notified at once. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. 100 9th Street, #101 20707 23a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 X No Yes Specify: White Yes 2 X No specify: Divorced Yes, Give Year Widowed <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) s 1 and 2 should be filed within 72 he of Health and Mental Hygiene. If item 27 is marked other than "na er traumatic event, the Modical Free Traumatic event, the Modical Free Traumatic event. College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Own Home Homemaker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Anne Coleman Be James Dudley Tarr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 9th Street, #101, Laurel, Maryland 20707 Mark David Luber 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition timore, crematory or other place) permit. Pages 1 Department of H Important: If it Removal from State 1 X Burial 2 Cremation 3 July 30,07 Laurel, Maryland Ivy Hill Cemetery Donation 5 Other Specify: 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Part I. Enter the presence, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Death **IMadica** Acetamino hen intoxication omplicating liver cirrhosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Profer this certificate has been signed by the attending physician and Permeral Director. After this certificate has been signed by the attending physician and etter filled in by the funeral director, page 2 should be deached for use as the burial - transit Physician/Medical X UNPENDED perME_G870. .28a-f Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown β Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other: DOA 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: Natural 1 Yes 2 y No 5 Pending unk July 25, 2007 unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be or Town, State)
104 Thrift Rd. Chestertown MD 3 Suicide determined (Specify) other-scene Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fun completely Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif July 26, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 30+ **Physician** 2:11 PM 2007 Harry Miller /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Singi Hospita 25/timos CI N/AIf Under If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□F Director 6/07/1909 212-08-4810 Usual Residence of Decedent Md10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show iral", or items 23a or 28a-f shov Examiner must be notified at 1□Yes 2□No Director Md. N/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2900 Biarman Avenue 21215 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2√2 No Specify. Specify: Baltimore, Maryland 21215-003 3 Widowed 4 □ Divorced White item 27 is marked other than "natural", other traumatic event, the Medical Exa Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Electrican Electrical 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Elizabeth Williams - Daughter</u> 5511 Anthony Avenue Baltimore Md. e | 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens Of Faith 8/04/2007 Baltimore Md permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarda Funeral Home 2829 Hudson St. Balto. 21224 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** -) theroscientic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes 1□ Yes 2□ No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of funeral 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day Year) Injury 1 Natural 5 Pending 1 TYes 2 TNo investigation 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of pe of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

Year)

200

AUG 0

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend 19b, perFH, g870, 8/1/07 TT Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 00:50 AM therine JUL 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL AGNES Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex A. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 225-68-993 60 19,1944 NC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at NIA 1 Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number **2122**3 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 NO 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Black Completed by 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than, College (1-4or 5+) if Health and Mental Hygiene. clothes Industr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Baker St. Baltimore, MD 21217

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.A. Ballo, more Dames 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7-27-07 Balto 5 Other (Specify) 4 ☐ Donation 21. Signature of Puneral Service Licenses P. March F/H Balto, MU Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest En ... the disease, or complication. hat caused the death. Immediat cause (Final disease condition resulting in death) Physician 5 DAYS RESPIRATORY /Medical Due to (or as a consequence of): Examiner 5 DAKS CVA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir CARCINDMA SOUAMOUS CE LL Jn Known Box 68760. ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No P.0. 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, pag 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Medical Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24, 2007 000 2500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NGOUNGNA 900 CATON AVENUE BALTIMORE, MO EMENNE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 1 2007

DHMH 17 Rev 1/2001

Registrar

within 24 hours after death

To the Funeral Director:
completely filled in by the f

OCME 2006

29a. Certifier 1

29b. Signature and title of certifie

JOLYL

뗭

State

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

25.

2007

Assistant Medical Examiner

30. Name and address of person who complete cause of death (Item 23a)

and manner stated

MM

32. Registrar's Signature

LANGE SANSON

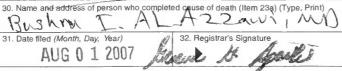
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 07 **Physician** Christine McBride 2007 2:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manorcare - Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29, 1965 9. Birthplace (State or Foreign **Funeral** Davs Months Hours 1 □ M 2 🗓 F 218-86-4308 42 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits tXXYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or ? 1131 North Mount Street 21217 USA Funeral 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1X Never Married 2 Married 2**X** No altimore, Maryland 21215-0036 Specify: African 1 ☐ Yes 2 X No Specify ģ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 warehouse clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Moore Annette McBride ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or other trau Carla Brown / Daughter 1131 N. Mount Street; Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/04/2007 Mount Zion Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5700 NO /Medical Due to (or as a consequence 1) un Known Examiner Datit if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 120 The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be \$ 1 Tes 2 No 3 Probably 4 Unknown Be Completed MS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【 No 24a. Was an page 2 s autopsy performed? Yes 2 2 No certificate 1∐ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

KARI 31. Date filed (Month, Day, Year) AUG 0 1 2007

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10061485

01103 Franklin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month **Physician** 6:55 PM Patricia Duffin McPhail Ju₁y 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🕅 F 84 216-46-3319 October 6,1922 Canada Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Baltimore Baltimore notifled Director 28a-f 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 7013 Charles Ridge Rd. 21204 Canada Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after on the Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or item 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: þ 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Duffin Elsie (unknown) ၉ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane McPhail Velez/dtr.-in-law 10 McCurley Dr. New Freedom, PA 17349 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery Aug. 1,2007 Pikesville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DAYS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner DISEASE physician and the burial-trai Division or Vital Records, P.O. Box 68760, as the l attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 Ho
9 Unknown Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ∐Yes the Hospital or Attending Physician:

25. Was case referred to medical exagniner? examiner: 1**X**Yes 2∐ No

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE

28d. Describe how injury occurred FALL DUE TO STROKE

0845 . M July 24-2007 1 ☐ Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

determined 4 Homicide HOME

7013 CHARLES RIGE Rd, TOWSON MA Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

26. Place of Death (Check only one)

29b. Signature and title of cortifier

1 2007

5 Pending investigation

6 ☐ Could not be

D64395

JULY 27, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. CHAPLES ST, BALTIMORE, MO 21204 DANIEUE DOBERMAN, MO

31. Date filed (Month, Day, Year) State AUG 0 Registrar

Be

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Certification:

Medical

732. Registrar's Signature

within 24 hours a To the Funeral 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25 Day 500. Wilbert Ε. Merchant /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2Himore 62 Homore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral X** M 2 F Director 89 18 MD 215-14-7766 Usual Residence of Deceder death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene "natural", or items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ite Medical Examiner must be notified at 1√Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3202 West Strathmore Ave 21215 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Principal 12th grade 5yrs+ School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Merchant Agnes Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200. Place of Disposition (Name of cemetery, crematory or other place)

200. Place of Disposition (Name of cemetery, crematory or other place)

Date

200. Location - City or Town, State Jacqueline Merchant-Wife
20a. Method of Disposition Notate 4 Donation 5 Dother (Specify) Woodlawn 8/1/2007 Baltimore Co, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses ala 4300 Wabash Ave, Baltimore, Md 21215 23a. art1. Enter the disease, or control that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Bowel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760s Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No ၉ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. ignature a d title of certifie 29d. Date signed (Month, Day, Year)

SA COSA

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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SINM HOSPITAL

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100	Dio. th	M)	1) LA	540	70	6	17/0	57	
	completed cause of	of death (Item 2	3a) (Type	Print)							
person who					5. Wa	shingt	on, DC 20	010			
P	of certifier of person who ta, MD,	Medical Examiner: On the basis and manner of certifier of person who completed cause of ta, MD, 106 Irv	Medical Examiner: On the basis of examination and manner stated. of certifier of person who completed cause of death (Item 2) ta, MD, 106 Irving Str	Medical Examiner: On the basis of examination and/or in and manner stated. of certifier of person who completed cause of death (Item 23a) (Type, ta, MD, 106 Irving Street M	Medical Examiner: On the basis of examination and/or investigation, and manner stated. of certifier of person who completed cause of death (Item 23a) (Type, Print) ta, MD, 106 Irving Street NW #41	Medical Examiner: On the basis of examination and/or investigation, in my op and manner stated. Of certifier Of person who completed cause of death (Item 23a) (Type, Print) La, MD, 106 Irving Street NW #415 Wa	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated. Of certifier Of person who completed cause of death (Item 23a) (Type, Print) La, MD, 106 Irving Street NW #415 Washington	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated. 29c. License number D 45490 of person who completed cause of death (Item 23a) (Type, Print) ta, MD, 106 Irving Street NW #415, Washington, DC 200	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated. 29c. License number 29d. Dat 29d.	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. Of certifier 29c. License number 29d. Date signed (M 6 17 (C) Of person who completed cause of death (Item 23a) (Type, Print) La, MD, 106 Irving Street NW #415 Washington, DC 20010	of certifier 29c. License number D45490 61767 D45490 D454

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			1- State of Maryland / Department of Head State of Maryland / Department of Head Certificate of Department of Head State of Maryland / Department /		ental Hygie Reg.	711111	24592
	9		Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Thomas W Mecrany		7 2	82007	0755 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo			4c. County of Deat	h
			John Hapkins Bayuness Cere Center BALTIM 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 18		Data of Birdh	0.81	halana (Chaha an Faraira
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II Months Days 1 12 M 2 F 57 Yrs.	Hours Min.	B. Date of Birth (Month, Day, Ye	ear) Co	hplace (State or Foreign untry)
			Usual Residence of Decedent		06, 14, 1	950	710
	rylan thow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic evant, the Medical Exameration to interfer notified at once.	by Funeral	Armed Forces? If Yes, specify Cuban, 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No	Mexican, Puerto R Specify:	ican, etc.)	Black, White	e, etc.
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Вох	death certific e attending p d for use as '	Physician/M	25b. Was decement pregnant in the past 12 months? 1			Month	Day Year
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1	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$550 5	Hofkins	Bayvier D 2/1	1/28/ v Circle 24	
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4	State	Sa' Pokharel 31. Date filed (Month, Day, Year)	Mercy Med (1) 3 Registrar's Signature	eal Cent	301 St	. Paul Pl.,	Bal	to, MD	21202

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Louis Melvin Ochlezh, Jr

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 01.50 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Fime of Death Day Year Catherine Rosalia O'Donnell AKA Rosalie Mary O'DonnellJuly 7:00 P.M 30, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 15, 19 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛚 F 216-05-0023 92 1915 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/AMaryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4020 Wilsby Avenue U.S.A. 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Richard O'Donnell Agnes Haydock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Bena (cousin) 4020 Wilsby Avenue Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 4 Donation 5 Other (Specify) 8-2-07 Baltimore, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the discusse, or complications that caused the leath. Do not enter the more of dying, such as cardiae er respiratory arrest, shock, or heart failure. List only one cause on each list. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 0= FEN 5,00 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2X No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

/Medical **Examiner**

Physician

permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other treasment.

Baltimore, Maryland

Physician

/Medical

Examiner

Funeral

Director

rat", or Items 23a or 28a-f show Examiner must be notifled at

Funeral

Completed

Be ဂ

with the Maryland

After this

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 📉 No 9 Unknown Part II. Other ificant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be P 1 Yes 2X No 27. Manner of Death Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature

DHMH 17 Rev 1/2001

		•	1 - For State Registrar	State of M	aryland / De		of H	ealth a		ental Hyg		_	21:	596
	Physici: /Medic		1. Decedent's Name (First, Middle, I	POPUL	-i				2	2. Date of Dea Month	Day	2007	0	ne of Death
	Examin		4a. Facility Name (If not institution, g Genesis Cromu		_	To	וספשכ				B	County of Dea		
	Funeral Director		5. Social Security Number 216-03-4222 Usual Residence of Decedent		96 (In yrs. last birthd 93 Yrs	Months	1 Year Days	If Under Hours	Min. A	B. Date of Birth (Month, Day pril 2	, Year) , 19	9. Bir 114 M	thplace (St. ountry) arylai	ate or Foreign
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99	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show the Modical Examitrer rust be ricillised at	/ Funera	11. Marital Status y□ Never Married 2□ Married	12. Was Decedent Armed Forces? 1 \(\superscript{Yes} \) 2 \(\superscript{X} \)	Ever in U.S. 1	3. Was Deced If Yes, spec				ify Yes or No- ican, etc.)		14. Race - Am Black, Whi	te, etc.	
Maryland 21215-0036	id be filed within 72 hours after desental Hygiene. ked other than "neturel", or tlems ic event, the Modical Examiliar ro	leted by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest of	Year or Dates: Education	16a. De	cedent's Usua ive kind of wor a. DO NOT us				7		nd of Business	industry الم	.te
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Baltimore,	permit. Pages. Department of I- Importent: If ite eny injury or of		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe 21. Signature of Funeral □ ervice □ in	oify)	Most Ho	ly Rede	emei	s of Facilit	8-4-0 y			ltimore -	e, Md	
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Vital Records,		Completed								24a. Was autop perior 1 Yes	sy	prior to death?		ngs available of cause of
Vita	Physicien: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpa	tient 3 DC	A Othe			Check only o		3 □Other (Spe	ecify)	
Division of	ath. r: After	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ury 28b. Tim	e of 2	Bc. Injury Work	at	28	3d. Describe h				
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	To the Hosp within 24 ho To the Fune completely fi	Medical	one)	Physicien: To the best eminer: On the basis of and manner st	of examination and/o	r investigation,	in my or	oinion, dea	id place, an	at the time,	date and	place, and du	e to the cau	
)	To With	N	29b. Signature and title of certifier F. Leles	to me	>			number	7/7			e signed (Mon	-	
-	り		30. Name and address of person where the second sec	DELGAS	death (Item 23a) (Ty	pe, Print)	M6	EI	20	BAL	-70	131/6	21,	234
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1	2007 32. Registr	rar's Signature	Jane						,		
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Gertrude Purvis 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland eneral 8. Date of Birth (Mooth, Day, Year 9. Birthplace (State or Foreign In vrs. last birthday) Social Security Number **Funeral** Hours 1 □ M 2XXF 220-30-0129 March 8, 1932 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 N. Gilmor Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married African 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Burgess Elmira Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn Thomas / Daughter 3826 Bonview Avenue; Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 08/07/2007 Baltimore, Maryland Mount Zion Cemetery 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 North Gilmor Street; Baltimore, Maryland 21217 Qlues 23a. Part1. Enter the disease, or complicant as that caus shock, or heart failure. List only one cause on each ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical 1 obe Preumonia **Examiner** Lower if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed signed by the attending physician and a bedached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 0 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 | Yes 20 No မ 2 ER/Outpatient 3 DOA after death. 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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NWACHUKNU, MD

32. Segistrar's Signature

m.D. C

30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

Kenna Nwach UKwu

AUG 0

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 11:10 AM 30 2007 EUGENE PATTERSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE der 1 Year | If Under UNION MEMORIAL HOSPITAL Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 1**A**M 2□F Days Hours Months Min. Yrs MAY 5, 1924 NC 83 216-18-4480 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f show Examiner must be notified at 1 ¥ Yes 2 □ No Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 USA items 23a 1552 MORELAND AVENUE Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant 1 is marked other than "natural", or items 23 ant: If item 27 is marked other than "natural", or items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 Specify: <u></u> 3 Widowed 4 Divorced BLACK er than "natur, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANICAL MAINTENANCE BETHLEHEM STEEL permit. Pages 1 and 2 should be filer. Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, ; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JASPER PATTERSON BEATRICE ROBINSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 DORIS PATTERSON/WIFE 1552 MORELAND AVENUE BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) 8-6-2007 KINGS MOUNTAIN, NC MT. OLIVE CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. ton BALTIMORE, MD 1701-31 LAURENS ST. 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner 10 silur St. Limits y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tra Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 3 Probably 4 Unknown 1 ☐ Yes 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manne of Death 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death the filled in by within 24 hours a completely

EF 31. Date filed (Month, Day, essous 1 2007 Registrar's Signature

2 Medical

4 Homicide

(Check only one)

29b. Signature and title/

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

🖊 Certifying 🖟 hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

union

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 2007 3:55 а м Romeo Frances /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris | Months | Days | Hours | Min. | 8. Date of Birth | OCT. | 25, 1910 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F 96 219-10-4391 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any onee. 10b. County 1 ☐ Yes 2 X No Timonium Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21093 USA 2300 Dulaney Valley Rd. Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tailor Shop Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK NOWN Thomas Vito 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 77 Laurel Path Court Baltimore, Md. 21236 Ms. Theresa Michael/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-2-07 Timonium, Md. Dulaney Valley Mem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License ^{22. Name and Address of Facility} Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-trai Due to (or as a consequence of) the attending physician Division or Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No 9 ☐ Unknow been signed by Part II. r significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Were 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 1∐ Yes 2 📉 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

FRANCES ROMEO

DHMH 17 Rev 1/2001

State

Registrar

of certifier

AUG 0

DR. EDDIE NAKHUDA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

007

29b. Signature and

2300 DULANEY VALLEY RD.

32. Registral's Signature

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

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Ernestir	ne Rouse		pence S 1- For State Registrar	tate of Maryla		epartment o C <i>ertificate o</i>		and Mei	ntal Hy	_	Reg. No	2 (7 2460
		an/	1. Decedent's Name (First, Mid-	die,Last)						2. Date of De	ath	Year		3. Time of Death 1506 hrs
M.	al Exami	ner	Ernestine Ro		ımber)		4b. City, Town	or Location	of Death	Month July 26,		c. County of	Death	1506 nrs
food			Harbor Hospital	ion, give ou ou and m			Baltimore					,		
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1		der 24Hrs.	8. Date of E	Birth(MN	//DD/YYYY)	g. Birth Foreign	place (State or
1	Director		213-64-0607	1 M 2XXF		54 Yrs		Days Hou	rs Min.	Feb.	11,	1953	Cour	ntry) MID
	4.	- [Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c	City, Town or Loca	tion							10d. Inside City Limits
	d how an		MD	,			Baltim	ore					- 1	1 X Yes 2 No
	arylan 8a-f sl at onc	Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·			10f. Zip Cod	le			10g. C	itizen of Wha	at Count	ry?
	the M							212	21225			USA		
	death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status 1 Never Married 2	12. Was De Armed F			as Decedent of				N 0-	14. Race - White,		an Indian, Black,
	or deat	Fun		1 Yes	2 X		Yes 2 X			,,				erican
	urs aft tural" amine	d by	15. Decedent's Education (Sp	or Dates:	1.61	ed) 16a. Decede	nt's Usual Occ	upation (Giv	e kind of w		16b	. Kind of Bus	iness/In	dustry
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5-0036	within iene. er tha	Ę.	12				CINA			78		nursing	3	
15-	al Hyg	Be Co	17. Father's Name (First, Middl Jer	e, Last) ry V. Rouser				18.Moth		(First, Middle san Whit		n Surname)		
2121	Ment Mark mark	To B	19a. Informant's Name/Relation	nship (Type, Print)		100	g Address (S		umber or R	ural Route N	umber,	•		. ,
₩ Q	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatte event, the Medical Examiner must be notified at once.		Anthony D. Yo	ung / Son			Orpin Ro		t. 201					
Je,	s l an of Hea If iter		20a. Method of Disposition 1 X Burial 2 Crematic	on 3 Removal f		20b. Place of Dispo crematory or o		f cemetery,		Date	200	. Location -	City or T	own, State
Baltimore,	Page ment tant: or of		4 Donation 5 Other	Specify:		King Memor:				3/2007				Maryland
Ball	Depar Impor injury		21. Signature of Funeral Service	celicensee		22.	Name and Add			ylie Fur reet: Ba				nd 21217
	ysician	\exists	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval											
1 M	executed an and and and and and and and and and		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Death											
-			or condition resulting in death) Due to (or as a consequence of):											
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last (Due to (or as a consequence of):											
		Examiner												
•	e be executed ysician and burial - transit	dical	UNPENDED	AMENDED			-							
68760	ficate g g phys s the bu	ian/Me	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes,	outcome of		etal death	3 Ecto	pic pregna	ncv	2	23d. Date of o		ay Year
39 ×	he death certificate / the attending phys hed for use as the b	<u>.</u>	past 12 months?	4 Preg	nant at time	of dooth	ther (Specify)	0	pio progridi			World		100
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<u>~</u>	ysician; The his certificate director, page		25. Was case referred to media	cal		-	26.F	lace of Deat	th (Check o		5 Z 🔻	140	16.	2 140
Vita	hysicis this ce il direc	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗸 ER/Outpatier	nt 3 DOA	Other ₄	Nursing	g Home 5	Resi	dence 6	Other:	
	ding Ph	T:uo	27. Manner of Death 1 ✓ Natural 5		e of Injury h, Day,Year)	28b. Time of	·	Injury at Wo		28d. Describ	e how i	njury occurre	ed	
Division	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	rtification	Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City											
Divi	Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	ertifi		termined (Specify		At none, ram, sur	oci, idolory, on	oo ballaliig,		or Town			. 0	arroate Namber, On
	Hospi 24 hou Funer stely fi	O	29a. Certifier 1 Certifying	Physician: To the be	st of my kno	wledge, death occu	irred at the tim	e, date and	place, and	due to the ca	use(s)	and manner	as state	d.
	To the Hospital or Attend within 24 hours after death To the Funeral Directors completely filled in by the	ledical		aminer:On the basis and manner	of examinat stated.	tion and/or investig				t the time, da				
		Ž	29b. Signature and title of certi	N 1	1/2			cense numb .C.M.E.	er			d. Date signe uly 27, 200		th, Day, Year)
-			30. Name and address of person	on who completely se	ISB of doals	(Item 22a)		. O. IVI. L.						
-	y		Susan Hogan MD.	Assistant Medi			nn Street, E	Baltimore	, MD 212	201				
	St Regis	tate	31. Date filed (Month, Day Yea	007 32. R	egistrar's S	gnature	9							

Christopher Robothan 07-05730

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar . Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 26, 2007 0930 hrs Medical Examiner Robotham Christopher

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1600 Block Waverly Way If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Country) Days Months Hours Director **1** M 2 01 29 70 Jamaica 767-26-4616 37 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No items 23a or 28a-f show Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Healand Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Randallstown Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Jamaica 21133 U.S.A. 8714 Church Lane Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Black 3 Widowed If Yes, Give Year 1 Yes 2X No specify: Specify: 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sunrise Courrier Laborer <u>10th grade</u> na 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Belinda Watson Renford Haymore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) 13579 Texas Woods Cir., Orlando, Fl 32824 <u>Lisa R. Beasley-Wife</u> Unk 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 XCremation 3 Removal from State 8/9/2007 Baltimore, Md Donation 5 Metro Crematory Other Specif 22. Name and Address of Facility 21. Signature of Funeral Service Lig Pson Uml /hom <u> 1300 Wabash Ave, Baltimore, Md</u> 23a. Part I. Enter the disease, or complications that cau 🖟 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and fail ve. List only one cause on each line. /Madical Death a. Blunt Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last e attending physician and for use as the burial - transi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical AMENDED TIFM/10g, perFH, C870, 8/1/07, WS UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death Month Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown signed by the ar Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed this certificate has been si I director, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 2 No No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes After t funeral 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject asaulted FOUND: Natura Yes 2 V No Pending To the Funeral Director: completely filled in by the Jul 26, 2007 0930 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Found: 1600 Bl. Waverly Way, Baltimore, Md (Specify) unknown 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 26, 2007 30. Name and address of person who completed cause of death (Item 23a)

Registra

Carol Allan, MD State 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32 Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** JULY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTH WEST ANDAIISTOU HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Days 219.40.345 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No MI BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? GIST AVE "natural", or Items 23a or 3 21215 45 by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Heatth and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23.

Lry or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 34 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCKING DOCK WORKER 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KICHARD WILLIAM ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DAUG White HURST DR. ISACTIO, MID AN GELA 20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMI. 20c. Location - City or Town, State 20a. Method of Disposition Date 813107 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, BALTIOND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Phillips fun GRAL NOME. Tar 1721-27 N. MOTUNEST, BALTIA NO 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9□Unknown 9 Unknown Part A Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 Tes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 24 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital or within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Defining Financial. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

311 State

31. Date filed (Month, Day, Year)

Bellevi

AUG 0

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 SMITH AVE SUITEZS, BAUD MI) 2120 strar's Signature

Registrar

	1- For State Registrar	Certificate of	Health and Mental H	Reg.	No. 200	7 2460		
Physician/ edical Examiner	Decedent's Name (First, Middle, Last) Brandon	Date of Death Month D	av Year	3. Time of Death 1925 hrs				
eulcai Examinei	4a. Facility Name (if not institution, give street and number)		b. City, Town, or Location of Death	July 25, 200	4c. County of Death	10201113		
	Howard County General Hospital		Columbia	4 1 1	Howard			
Funeral Director		(In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Birthplace (State or Foreign			
Birestor	169-66-4626 1 XM 2 F 2	25 Yrs.		Oct 29,	ntry) PA			
any.		10c. City, Town or Locati	on	-		10d. Inside City Limits		
·land ·f shov once,	MD Howard	Columbia				1 X Yes 2 No		
the Maryland a or 28a-f she tified at once	10e. Street and Number	" -	10f, Zip Code	77.	Citizen of What Count	ry?		
death with the Maryland or items 23a or 28a-f show must be notified at once.	5003 Green Mountain Circle 11. Mantal Status 12. Was Decedent B		21044 s Decedent of Hispanic Origin? (S		U.S.A. 14. Race - Americ	an Indian, Black,		
or items 23		X No	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.			
	3 Widowed 4 Divorced of Parks: 15. Decedent's Education (Specify only highest grade comp		Yes 2 X No specify: t's Usual Occupation (Give kind of	work dono	Specify: Whit			
5-0036 ed within 72 hours tygiene. other than "natu he Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5-	during m	ost of working life. DO NOT use ret			dustry		
vithin 7	1	Dog S:			Pet Care			
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene 127 is marked other than umatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last)		20.	(First, Middle, Mai	iden Surname)			
D 2121 should be fi and Mental 7 is marked natic event, To Be	Mark B. Reed 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Number or	L. Shaw Rural Route Numbe	er, City or Town, State,	Zip Code)		
	Mark B. Reed /father		Old Rt 30, Orrta					
altimore, altimore, mit. Pages I an apartment of Hea apportant: If itee	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	1	ition (Name of cemetery, ner place)	Date 2	20c. Location - City or	own, State		
ti. Pag rtment ortant:	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Crematory Jul	31, 07	Odenton, N	Maryland		
Balti permit. Departin Importi	A Jak Harry	M00773 3	ame and Address of Facility Onaldson Funeral 13 Talbott Ave.	Home, P.	.A. Marvland 20	707-4389		
Physician	23a. Part I. Enter the disease, or complications that caused t failure. List only one cause on each line.					Approximate Interval Between Onset and		
/Medical	Immediate Cause (Final disease or condition resulting in death) a Asphyxia by hanging Due to (or as a consequence of):							
1	Sequentially list conditions, b.							
iner	if any, leading to immediate Due to (or as a consect cause. Enter Underlying Cause	quence of):						
ted nisit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consecutive form)	quence of):						
	d. X UNPENDED AMENDED AMENDED 200							
60, ate be exe ohysician te burial -	IF FEMALE: 23c. If yes, outcom	a-f, perME,g870	0, 8/8/07 TT		23d. Date of delivery			
30x 6876/death certificate e attending phy I for use as the b	23b. Was decedent pregnant in the past 12 months?	2 Fe	tal death 3 Ectopic pregn	ancy	Month D	ay Year		
J. Box 68760, the death certificate be executed that the attending physician and each for use as the burial - traphysician/Medical	1 Yes 2 No 9 Unknown 9 Unknown	ot of dealing 5 Ot	her (Specify)		:			
s, P.O. Be irres that the de r signed by the de detached f be detached fed by Phy.	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given in Part I.		acco use contribute to t	_		
duires quires en sign				24a. Was an	2 No 3 Prob	opsy findings available		
Records, The law requires ficate has been sig page 2 should be Completed				autopsy perform	prior to c ed? death?	ompletion of cause of		
tal Recian: The certificate ector, page	25. Was case referred to medical		26.Place of Death (Check	1 ✓ Yes 2	No 1 ✔ Ye	s 2 No		
of Vital Records, and Physician: The law require this certificate has been a meral director, page 2 should no. To Be Completed.	examiner?	nt 2 🕶 ER/Outpatient	Othor		esidence 6 Other			
ting Pl After funeral	27. Manner of Death 28a. Date of Injur (Month, Day, Ye	ry 28b. Time of I		28d. Describe ho	w injury occurred			
Division tal or Attending a strend cast. Al Director: Aled in by the fulcion by	2 Accident Investigation July 25.	2007 Fnd 6:30	pm 1 Yes 2 X No et, factory, office building, etc.	subject ha		al Route Number, City		
Division o septial or Attending hours after death. neral Director: After y filled in by the fune Certification:	Suicide 6 Could not be	iail	st, ractory, office ballaring, etc.	or Town Sta				
	29a. Certifier 1 Certifying Physician: To the best of my			d due to the cause(s) and manner as state	ed.		
To the Ile within 24 To the Fu complete!	one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	iiriation and/or investiga	29c. License number		29d. Date signed (Mor			
	14/1/1/1/1) ,	O.C.M.E. July 26, 2007					
07	30. Name and address of person who completed cause of de	eath (Item 23a)						
U	Zabiullah Ali, M.D. Assistant Medical Ex		n Street, Baltimore, MD 2	1201				
State Registra	31. Date filed (Month, Day, Year) 32. Register AUG 0 1 200 7	's Signature	park					

			State of Maryla	•	artment of H rtificate of I		d Mental Hy	2 2 2 2	01.01
	£		1. Decedent's Name (First, Middle, Last) 2. Date of Death						3. Time of Death
	Physic /Med		Clara I. Rosenthal			July	27 2007	8:40а м	
	Exami	_	4a. Facility Name (If not institution, give street and number) Stella MAris Hospice		4b. City, Town, or TOWSO		eath	4c. County of Dear Baltim	ore
ĺ	Funeral Director		218-05-4892 ¹□M 3K□F 86	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of B	マップ ^{ar)} 1921 ^{Co}	thplace (State or Foreign ountry) aryland
	aryland show d at	<u>_</u>	Usual Residence of Decedent	City, Town or Lo	ocation cimore				10d. Inside City Limits 1 ☐ Yes 2 X No
	th the Ma or 28a-f	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	
	ath wi 23a ust b	lal	1011 S. Binney Street		212			USA	vicen Indian
1. 920	filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. After than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Midowed 4 □ Divorced 12. Was Decedent Ever i Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin' an, Mexican, P Specify:	/ (Specity Yes or Nuerto Rican, etc.)	Black, Whit	
0 a.m.	Ithin 72 ho le. lan "natur Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup e kind of work done o DO NOT use retired	ation during most of f)	working	Restau	
8:40	be filed w tal Hygier d other the	Be	4th 17. Father's Name (<i>First, Middle, Last</i>) Joseph Swinder	Cool	<u>C</u>		Name (First, Middle M. Bru	le, Maiden Surname)	
	2 shoul and Mals mari	P	19a. Informant's Name/Relationship (Type. Print) Elizabeth C.McFaul	19b. Maili 6116	ing Address (Street MArgle	and Number o	r Rural Route Num enue Ba	iber, City or Town, State, . ltimore MD	Zip Code) 21206
~	Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Disposition	Db. Place of Dispo cemetery, cre OAk Lav	osition (Name of ematory or other place wn Cemet	ery 7	/31/07	20c. Location - City or Baltimore	
JULY 27,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee	_		, Fune	ral Hom	e Ave.Balt e of Essex	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) DEMENTIA						
	/Medical		resulting in death) Due to (or as a cor	sequence of):					
	Examine		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	cuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):						
0760	cate be executed only sician and the burial-transit	dical Ex	d	sequence or):					
9	ath certification of the control of	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify)	y		23d. Date of de Month	elivery Day Year
THAL	quires that the densigned by the s	þ	Part II. Other significant conditions contributing to death but not	t resulting in the u	underlying cause giv	en in Part I.		d tobacco use contribute t ☐ Yes 2 ☐ No 3 ☐ F	
	law as b	Completed					— 24a. Wa au pe 1∐ Yes	topsy prior to rformed? death?	
RA	vital siclan: T certificate irector, pa	Be	25. Was case referred to medical examiner?	-	Ott	or:	Death (Check onl		
G.	Phy r this	1.1	27. Manner of Death 28a, Date of Injury	2 ER/Outpatie		4 🗆 IYursi		e how injury occurred	ecify) HOSPICE
	Attending r death. ector: Afte on the fune	ation	1 Natural 5 □ Pending (Month, Day Year 2 □ Accident investigation 3 □ Suicide 6 □ Could not be		M 1□	Yes 2∐No			
	Ltal or Att s after de al Direct ed in by 1	Certification:	4 Homicide determined 200. Place of Injury building, etc. (Si	pecify)			City or 1	n (Street and Number or F Fown, State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my one) 1 X Certifying Physician: To the best of my one and manner stated.	knowledge, dea mination and/or i	investigation, in my	opinion, death	olace, and due to the occurred at the time	ne, date and place, and du	ue to the cause(s)
	To t Withi	Σ	29b. Signature and title of Certific	77	29c. Licens	se number	n fg	29d. Date signed (Mon	
	100		30. Name and address of person who completed cause of death						
	V	tate	DR. EDDIE NAKHUDA 2300 DUL 31. Date filed (Month, Day, Year) 32 Registrar's 3		LLEY RD.	TIMONI	UM, MD 2	1093	
	Regis		AUG 0 1 2007 Resignation		colles				

DHMH 17 Rev 1/2001

07-05834 Sophie Rhinier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

Soprile Palline		State Of Maryland 1- For State Registrar		e of Death	id Michael i		g. No. 2 f	107 01.60	
Physicia	in/	Decedent's Name (First, Middle,Last)				2. Date of Death Month July 30, 20	,54 /s	3. Time of Death	
Medical Exami	ner	Sophie 4a. Facility Name (if not institution, give street and number		Rhinier 4b. City, Town, or Location of Death			07	1300 hrs	
()		349 Bonsal Street	Baltimore			201.1	4c. County of E	peath	
Funeral Director		5. Social Security Number 218–28–5573 6. Sex 17. / 1 M 2X F	Age (In yrs. last birthd	ay) If Under 1 Ye Months Da Yrs.		8. Date of Birth Dec. 29	` F	B. Birthplace (State or foreign CountryMaryland	
any	Noscatt e p	10a. State 10b. County	10c. City, Town or	Location		<u> </u>		10d. Inside City Limits	
daryland 28a-f show 1 at once.	to	Maryland NA	Baltimo			7. 05.	21	1 X Yes 2 No	
after death with the Maryland al", or items 23a or 28a-f sho ner must be notified at once.	I Director	10e. Street and Number 349 South Bonsal Street		10f. Zip Code 21224	4	B- 24		U.S.A.	
er death wi	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 1 Yes		3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 X N	an, Mexican, Puerto		White, e	American Indian, Black, etc. White	
urs afte	d by	3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade c	ompleted) 16a. De	cedent's Usual Occup	•	ork done	Specify: 16b. Kind of Busin		
Baltimore, MD 21215-0036 permit. Pages I and 2 should; be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Completed	College (1-4 c 12 12 N A	or 5+) dui	ring most of working lif	e. DO NOT use retir	ed)	uranas Co		
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MD 21215-0036 de 2 should be filed within 7 lith and Menial Hygiene n 27 is marked other than aumatic event, the Medical	To Be	Eon 19a. Informant's Name/Relationship (Type, Print)	Boncew	vich Mailing Address (Stre	Vera	tural Dauta Numb	Pe	troff	
MD 2 shouth and 1 27 is numatic	۲	Kimble Pika (Nephew)						ryland 21050	
ore, is a and stream of Healt In item		20a. Method of Disposition 1 Burial 2 **Cremation 3 Removal from the second se	20b. Place of D	Disposition (Name of co	emetery, Augu	Date IS L	20c. Location - Ci	ty or Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:		Crematory		2007		re, Maryland	
Balt permit. Depart Impor- injury		21. Signature of Funeral Strvice Usens e 23a Party. Enfer the disease, or complications that aust	next	22. Name and Addres W. Dabrow	ss of Facility VSki/Chojr Nalk Avo	nacki Fu Baltimo	neral Ho re. Marv	mes P.A. land 21224	
Physician /Medical	7.0	failure. List only one cause on each line.			g, such as cardiac or	respiratory arres	st, shock, or heart	Between Onset and	
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60, ate be ex hysician e burial	Medical	UNPENDED AMENDED	_ =						
3876 rtificat ling ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome the past 12 months?	come of pregnancy 2	Fetal death 3	Ectopic pregna	ncy	23d. Date of de Month	livery Day Year	
Box 687 e death certific the attending of	Physician/	1 Yes 2 No 9 Unknown g Unknown	at time of death 5	Other (Specify)					
O. B. nat the d and the detached		Part II. Other significant conditions contributing to de	ath but not resulting ir	n the underlying cause	given in Part I.	23e. Did tob	acco use contribu	te to the cause of death?	
Division of Vital Records, P.O. fal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaid.	ed by					1 Yes		Probably 4 Unknown	
cords, law require has been s	Completed					24a. Was at autops perform	y prio	re autopsy findings available or to completion of cause of other	
tal Re(cian: The certificate ector, page		25. Was case referred to medical		20 F)	(1) (1) (0)	1 🗸 Yes 2		Yes 2 No	
Vital Rec hysician: The this certificate	m	examiner?	tient 2 ER/Outp	atient 3 DOA	Other Nursing		Residence 6 🗸	Other: Scene	
n of ding Ph.	ي: <u>۱</u>	27. Manner of Death 28a. Date of Ir (Month, Day	njury 28b. Tim		ury at Work?	28d. Describe ho	ow injury occurred		
ivision or Attend after death. Director: I in by the f	catio	Natural 5 Pending 2 Accident Investigation			Yes 2 No				
Division ospital or Attenchours after death meral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	Injury - At home, farm	, street, factory, office	building, etc.	or Town, Sta		or Rural Route Number, City	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner: On the basis of examiner:	kamination and/or inve						
To To	Medical	29b. Signature and title of certifier	1.	29c. Licen	se number		29d. Date signed	(Month, Day, Year)	
		Theodor Il Kore	TR.	0.0	.M.E. OCM	E	July 31, 2007		
10		30. Name and address of person who completed dause of Theodore M. King, Jr., MD. Assistant	,	er 111 Penn S	treet, Baltimore	, MD 21201			
St: Regist	ate	31. Date filed (MANT Coap Year) 2007 32 Regist	rar's Signature	book					
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Registrar
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32. Redistrar's Signature

SZALASNY

31. Date filed (Month, Day, Year)

Hospital of Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Elsie Marie Schneider /Medical August 1 2007 2:00 am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightwood Center Genesis Health Care Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year April 13, Social Security Number 9. Birthplace (State or Foreign Country) 1906 New Jersey **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours Months Days Year) 1 □ M 2 🔽 F 139-38-3631 101 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2XXII Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 515 Brightfield Road 21093 Funeral U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a ant: If item 27 is marked other than "natural", or them traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∐Yes 2**XX**0o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. þ Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rheinholt Nather Freda Rheim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 is any injury or other trauonce. George R. Schneider (Son) 2227 Wicomico Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 XX emoval from State 4 □ Donation 5 □ Other (Specify) Greenwood Cemetery 08/03/2007 Brielle, New Jersey nature of Funeral Service 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 23a. Part1. Enter the disease, or shock, or heart failure. List ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence /Medical Examiner ovorong Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) the 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 🛣 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death, neral Director: A filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I completely filled To the Hospital 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

uple 9650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shakunma

31. Date filed (Month)

Year)

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21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death	d Mental Hy	/giene Reg. No. 2 A	17 21.50				
	Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Time of Death				
			Genevieve Ann Sliwka	07	29 200					
			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath						
			Stella Maris Timonium, Mary	vland	Baltim	ore				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F			Birthplace (State or Foreign Country)				
	Director		212-07-5737 1 94 Yrs. 94	03/01	/1913 M	aryland				
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
	faryla sho ed at	5				1 Tyes 2 No				
	the N 28a-	Director	MD Baltimore Hydes 10e. Street and Number 10f. Zip Code		100 0161-00 -616/0-06					
	with a or t be r		1811 = 19 0000		10g. Citizen of What	Southty?				
	leath ns 23 mus	era	13033 Bottom Road 21082 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Ves or No	U.S.A.	merican Indian,				
	r iter	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Pt 1	ierto Rican, etc.)	Black, W					
036	urs a al", o Exarr	þ	3 X Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify:		Specify:	<i>N</i> hite				
Ç	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of		16b. Kind of Busine					
2	an ". Med	g	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	working	İ					
5	filed wi Hygien ther th	S	12 Homemaker		Own Hom	e				
ב	be filed within 72 hours after death with the Marylan tall Hygiene. 40 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifiled at	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Middle	, Maiden Surname)					
Z 2	should be filed within 72 hours after death with the Maryland wind Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ု		anna Mala						
5 P.M. Marvland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or							
	and fealth m 27 her tr		Robert R. Sliwka, Sr. (son) 13033 Bottom Road - 20a. Method of Disposition 20b. Place of Disposition (Name of employing explanation (souther deep)	- Hydes,	Maryland	21082				
6:	Pages 1 nent of H nt: If ite		1 X Burial 2 Cremation 3 Removal from State	Date	20c. Location - City	or Town, State				
3	Pa tmen tant: jury		4 Donation 5 Other (Specify) Holy Rosary Cemetery 08	3/02/2007	Baltimor	e, Maryland				
6:2 Baltimore	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility							
	2012 e 0		11750 Belair Road		<u>-</u>	yland 21087				
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each kine. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
٦	/Medical Examiner									
- 1		<u>.</u>								
- 7	ted nsit	i	Sequentially list conditions, if any, leading to immediate course. First a Locality of the Course (Disease or injury that initiated events c							
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2007	siciar buria	E E								
2007	g phy as the	edical	U							
9, 2 Box	death certi attending I for use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of	delivery				
29,	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ ★ 5 ☐ Other (specify)		Month	Day Year				
	the (ιysi	9 ☐ Unknown 9 ☐ Unknown							
JULY	s that	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?				
C	quire n sig uid bu	Q p		_ 10	Yes 2□No 3□	Probably Minknown				
S	sw res	lete	(Mensegra	24a. Was	an 24h Were	autopsy findings available				
KA B	The la	Completed	fl-fares-freus		psy prior to prmed? death	o completion of cause of ?				
SLIWKA JULY Vital Records. P.O		a	OF Weekenstein de medical	1 Yes Death (Check only o	251No 1 1 Y	es 2□No				
	ysicia s cer direct	To B	examiner?		dence 6 □Other (S					
ZE OF	Attending Physician: r death. ector: After this certific. by the funeral director,		27. Mainter of Death 28c. Injury at	28d. Describe	how injury occurred	јеспу)				
ENEVIEV Division	ath. r: Aft	atio	TS Hatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No							
EV.	al or Attendii s after death. I Director: A d in by the fu	ifice	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or	Rural Route Number,				
GENEVIEVE Division o	s afte	Certification:	building, etc. (Specify)	City or To	wn, State)					
9	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or	ace, and due to the	cause(s) and manner	as stated.				
	he H in 24 he F plete	edical	and manner stated.	ccurred at the time,	date and place, and c	ue to the cause(s)				
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number	3	29d. Date signed (Mo					
			1/25		7-30	.07				
	i.	Ì	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
_	U			VIUM, MD	21093					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature							
	. rogioti		2116 0 1 2007 Lawre La James							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 11:57 STURTEVANT 29 TERITA ZILLY 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death IOHNS HOPKINS HOSPITAL BALTIMORE Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2√2 F Yrs. 213-78-0474 42 65 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21218 <u> 2111 Barclay Street Apt B</u> U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2√2 No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Walmart llth grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Thompson Vivian Eaton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2604 Erdman Ave, Baltimore, Md Temika Sturtevant-Daughter 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Memorial Park 8/4/07 Randallstown, Md 21. Sign tur of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash ave, Baltimore, Md 21215 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE S DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Disease or nighty that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner certificate be executed burial-transit and Box 68760, physician Physician/Medical the as attending use ō P.O. the ģ signed Records, Completed een hast certificate Vital မ o this Certification: After or Attending Division

Physician

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r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

hours after

within 72

permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If them 27 is marked other thairman

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

within 24 hours are: Control To the Funeral Director: After To the Funeral Director: After To the Funeral Filled in by the funeral Funera Funeral Funeral Funeral Funeral Funeral Funeral Funeral Fune To the Hospital

State Registrar

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

M.D

P21168

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANSARI

and manner stated.

N. WOLFE STREET BALTIMORE MD 21287 600

KAHILA 31. Date filed (Month, Day, Year) AUG 1 2007

4 Homicide

29a. Certifier (Check only one)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Joan Ramona Shields /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Min. Months Davs Hours 1 M 2X F 214-24-7351 79 Director 05/16/1928 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1√Yes 2 No Baltimore be notified Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a 3738 Manchester Avenue 21215 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must. once. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 ∑Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical 10 Murse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Leander Dorsey Carrie Snowden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3738 Manchester Ave., Baltimore, Maryland 21215
ce of Disposition (Name of Date 20c. Location - City or Town, State Leslie Shields / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State Sacred Heart Cemetery 08/06/2007 Dundalk, Maryland 4 Donation 5 Dother (Specify) The Derrick C. Jones F/H, P.A.

4611 Park Hgts. Avenue, Baltimore, Maryland 21215

Approximate 21. Signature of Funeral Service License 4611 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one of Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Na Certification: To 1 🔲 Yes Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Deat 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat e Funeral Director n by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number Date signed (Month, Dav. Year) and title of certifie 30. Name 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** JULY Hazel Virginia Sparks 10:12F M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min 1 □ M 2 X F Director 164-12-4956 89 July 4, 1918 Virginia Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 2040 High Point Road 21050 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **№** No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Developer Real Estate alth and Mental Hygic 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Clarence Waddell ဂ္ Ina Gertrude Waddell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma G. Guercio / Daughter permit. Pages 1 a.
Department of Heal
Important: If item 2,
any injury control P.O. Box 148, Fallston, Maryland 21047 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 7-30-07 Bel Air, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC SQUAMOUS CELL /Medical Due to (or as a consequence of) **Examiner** CARCINOMA OF THE LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 1 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy performe death? 1 ☐ Yes 2 17 No 2∏ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Impatient 9 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 4 hours after death. Funeral Director: After t After 1 Certification: 1. ■ Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D 7601 D
32. Augistrar's Signature CEBALLOS. OSLER DRIVE TOWSON. ILIA MARYLAND 31. Date filed (Month, Day, Year) State 1 2007 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Rodney Stewart		State of Maryland / Department of Health and Mental H		. No. 200	17 21:61
Physician/		legistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Medical Examine		Rodney Stewart	July 28, 200	4c. County of Death	0944 hrs
	1	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore		N/A	'
Funeral	ŧ	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	 .	(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director		218-64-1460 1XM 2 F 50 Yrs. Months Days Hours Min	8/12/1		puntry) Md.
	~ ~	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
d G.		Md. N/A Baltimore			1 X Yes 2 No
the Maryland at or 28a-f show iffed at once.	<u> </u>	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	intry?
Dir the D		2721 Baker Street 21216	3 - 00	USA	
r death with or items 23 must be no	2	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	rican Indian, Black,
ter dea		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2XX No specify:	5 = 2	Specify: Bla	ıck
atural aming	3	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Business	/Industry
5-0036 for within 72 hours after the within 72 hours after the flygiene other than "natural"; the Medical Examiner Completed by 1		Elementary/Secondary (0-12) College (1-4 or 5+)	(iied)	NT	
-003 I withii giene. ther th	<u> </u>	12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M	Never Wo	гкеа
215-0036 b. filed within 7 nial Hygiene ried other than e.t., the Medical Be Comple		Paul Stewart Delore	s Harı	cett	
Z plant S	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			
Biltimore, MD Penit Pages I and 2 sho Dosatment of Health and Important: If item 27 is injury or other traumati		Bernadette Harrison 2721 Baker St., Ba 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City o	r Town, State
iore ges 1 a t of Ha : If it	- 1	1 Burial 2 XCremation 3 Removal from State crematory or other place)	1 /2007	Catanari	llo Md
Baltimo permit. Pag Department Important:	/			Catonsvi	14
Balt pe mit Departi Import injury		21. Sphature of Funeral Service Lights Place Name and Service Lights Place 1300 Eutaw Place	e, Balt	imore; M	id. 21217
Physician /Medical	1	23a. Part I. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):			Dealit
	ı	Sequentially list conditions, b.			<u> </u>
red nisit		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c			
1,1 S is is 8	IX a	events resulting in death) Last Due to (or as a consequence of):			
60, ate be execut hysician and e burial - tra	<u> </u>	d			
760, ate be physici he buri		##ZOA, PII, Z7, DEN'IE, gO/U, O/ZZ/U/ II IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	•
68 certific nding ise as t	מוו	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	nancy	Month	Day Year
). Box 687 the death certific by the attending p ched for use as the	2	1 Yes 2 No 9 Unknown 9 Unknown			
P.O.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	o the cause of death?
duires quires and be	ed	Fatty liver	24a. Was a		autopsy findings available
Records, I The law requires ficate has been signage 2 should be		Chronic narcotism	autops	med? death?	
E. The liftcate or, page		Asthma 25. Was case referred to medical 26.Place of Death (Check	1 Yes 2	2 No 1 🗸 Y	Yes 2 No
Vital ysiciar his cer directo		eveniner?		Residence 6 Other	er:
of Of Mag Ph	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
sion attendi death.	310	1 X Natural 5 Pending Investigation Investigation Investigation	000 1	union and Milliantes and F	Dural David Number City
Division o spital or Attending bours after death. neral Director: After filled in by the func		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	or Town, St		Rural Route Number, City
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the cause	e(s) and manner as sta	ated.
To the Ho within 24 I To the Fu Completely		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and makiner stated.	at the time, date a		
1 de de 2	[≥	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (M July 29, 2007	onth, Day, Year)
DX 1	-	30. Name and address of person who completed cause of death (Item 23a)			
OCME		Mary G. Rippie MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, I	MD 21201		
Stat Registra		31. Date filed (Month, Day, Year) AUG 0 1 2007			
DHMH 17 Rev 1/200	_	ORIGINAL			
		ONGINAL			

Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,		ñ
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	Phy /M	pern
o the Funeral Director: After this certificate has been signed by the attending physician and	si lec	2 2

		For State	State of Mai	yland / Dep	partment o	f Health	and N			-	•
		Registrar		Ce	ertificate d	of Deat	'h		Reg. No.	200	7 24515
Physici	ian	1. Decedent's Name (First, Middle, La.			m 1			2. Date of Dea	Day	Yea	3. Fime of Death
/Medi Examir		Madeline 4a. Facility Name (If not institution, give	H •		Taylor		on of Doath	July	23	County of De	
EXCIIII	ier	-0- /- / 0	eral Hos	i tal	Balt	MURY		44	40.	County of De	eatri
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthda	/) If Under 1 Ye		ler 24 Hrs.	8. Date of Birth) (Voor)	9. E	irthplace (State or Foreign
Director		616-16-2004	M 2DF	96 Yrs.	Months Da	ys Hour		(Month, Day 08 19	1 (DC
and w		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or	_ocation						10d. Inside City Limits
Maryl -f sho ied a	ţō	MD		Baltim							1 Q Yes 2 No
h the or 28a o notif	Director	MD NA 10e. Street and Number		Daiti	10f. Zip Cod	le			10g. Citiz	zen of What (A
th wit 23a c 1st be	a D	2010 Rayner Av	2			2121	7			U.S.	Α.
er dea tems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		. Was Decedent If Yes, specify (ecify Yes or No- Rican, etc.)	1		nerican Indian,
hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 💢			i noun, oto.,		Cooniés.	
"n 72 hour "natural" edical Ex	ed k	15. Decedent's Ed	Year or Dates:	16a. Dec	edent's Usual Oc	cunation				nd of Busines	Black
hin 72 9. an "na Media	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Giv	e kind of work do DO NOT use re	one during m tired)	ost of work	ing	TOD. KII	id of Busilies	s/industry
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be filk tal Hy d oth event	Be (17. Father's Name (First, Middle, Last)						(First, Middle,	Maiden :	Surname)	
d Men narke	٩	William Tuarde						ardes			
d 2 sl th an th an 7 is r traur		19a. Informant's Name/Relationship (7		1	ling Address <i>(Str</i>						. Zip Code) 21216
s 1 ar f Hea item 2		Theodore Finck 20a. Method of Disposition	11119	20b. Place of Dispose cemetery, cri				Date			or Town, State
Pages lent o nt: If i		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			morial	i	0/2	107		•	town, Mđ
permit. Pages 1 and 2 should be lifed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.	1	21. Signature of Funeral Service Licen			22. Name and Adar Ch			/0/	Kam	Jairs	LOWII) MG
8 3 2 6		Mugues 1	J. Kek	4	300 Wal	oash	ave,	Balti	more	e, Md	21215
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not e	nter the mode of	dying, such	as cardiac o	or respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a prilater	al Me	umon	ia					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):							
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tuted d	Examiner	Sequentially list conditions, large cause. Enter Underlying Cause (Disease or injury that initiated events	Respira	tory F	arhere	2_					
te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):							
eath certificate be executed attending physician and for use as the burial-transit	lical		d								
ertific	Med	IF FEMALE:	00-16						-		
eath c attenc for us	ian/	in the past 12 months?	23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tin	Fetal death 3	□Ectopic pregna				2	3d. Date of d	elivery Day Year
The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne or death 5	Other (specify					Wiena	Day Tour
s that ned b	by Pr	Part II. Other significant conditions co	entributing to death but r	ot resulting in the	anderlying cause	given in Par	t I.	23e. Did tol	oacco us	e contribute	to the cause of death?
w require been sig should be								1 □ Ye	s 2] No 3 □ F	robably 4 Unknown
e law re has bee	plet							24a. Was a			utopsy findings available
The l	Completed							autops perform	ned?/	prior to death? 1 □ Ye	
Physician: The this certificate al director, pag	Be (25. Was case referred to medical examiner?					ce of Death	(Check only on		/	
× .2. ₽	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Impatient 28a. Date of Injury	2 ER/Outpatie	III SLI DOA			ne 5 Reside			əcify)
ding h. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) 28b. Time (njuryat Vork? □Yes 2[-	28d. Describe ho	w injury	occurred	
Atten r deat ector: by the	fica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury	- At home, farm, st				8f. Location (St	reet and	Number or F	Tural Route Number,
al or s afte al Dir	Certification:	4 Homicide	building, etc. (Specify)				City or Towr	, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	and House Wallber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1 Certifying Phy	sician: To the best of n	ny knowledge, dea	th occurred at the	e time, date	and place, a	and due to the ca	ause(s) a	and manner a	s stated.
the hin 24 the F	Medi		and manner stated	. 			eam occum	ed at the time, d	ate and p	place, and di	e to the cause(s)
Not Cop	_	29b. Signature and title of certifier			29c. Lice	nse number	00	2:	9d. Date	signed (Mon	th, Day, Year)
	-	O Salar 1 1	¥	//	0	766	4		_//	4210	/
2		30 Name and address of person who c	mr. m	1), 40	WIARI	Jana	(G1	enerau	1 1	Lospi	tal
∜ Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1000	/10.00		, ,			
Registra	ar	nuc 1 20	107 Kan	. H. A	seres.						
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 30.2007 **Physician** 12:17# M /Medical Facility Name (If not institution, give street and number) County of Death Examiner altimore 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 0696 Director Maryland death with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 1 Yes 2 □ No altimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 Divorced Completed by Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be annon Gertrude Cook

Physician /Medical **Examiner**

19a. Informant's Name/Relationship (Type. Print)

21. Signature of Funeral Service Licensee

eanine

20a. Method of Disposition

laylor

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

attending physician and for use as the burial-transi

Division or Vital Records, P.O. Box 68760,

	Vaugh (.)	neemo	872	8 Liberty na 1	Phandausta	m mo a	9 <i>113</i> 3
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ASMUCTU		or respiratory arrest,		Approximate Interval Between Onset and Death
alcal Evaluated	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	1			•
y Signature	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	il death 3 □Ectop	ic pregnancy (specify)		23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlyir	ng cause given in Part I.	M		o the cause of death? robably 4 □Unknown
- L					24a. Was an autopsy performed 1∐ Yes 2 M	? death?	utopsy findings available completion of cause of s 2 ☐ No
3	25. Was case referred to medical examiner?	Hospital:		T 0.11	ath (Check only one)		
2	1 Yes 2 No	1 Inpatient 2	ER/Outpatient 3		lome 5 ☐ Residence		ecity) MOSPICE
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	,
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of injury - At h building, etc. (Specia	ome, farm, street, fac fy)	tory, office	28f. Location (Street City or Town, St	and Number or Rate)	lural Route Number,
3013	29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my knominer: On the basis of examination and manner stated.	wledge, death occur ation and/or investiga	red at the time, date and place tion, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	29b. Signature and title of certifier	m		29c. License number D 58303	29d. [Date signed (Mon	th, Day, Year)

6701 Newoll StrowsW MD 21204

20b. Place of Disposition (Name of cemetery, crematory or other place)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

08.02.2001

57 Winding Brook Acad, Bosden Town, NJ 08505

22. Name and Address of Facility Vaughn C. Greene Juneau Struce

Boutimon, mo

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

AMON'S CHANCES

who completed cause of death (Item 23a) (Type, Print)

				1
		Physic /Medi	ian cal	
		Exami	ner	4
		Funeral Director		5
JULY 26, 2007 8:40 a.m.	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
	I	Physician		
		/Medical Examiner		ľ
RICHARD URCIOLO	Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	P P 2 2 2 2 2
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Decedent's Nan								Date of D Month		Day	Year	3. Time of Death
4- 5- 00 0			iolo					Ju1y		2007		8:40 A
_ ''		on, give street and number)		4b. City, Town, or		f Death			4c. County	of Death	
Stella 5. Social Security I		Hospice	(l	a biliner		onium	M 1 ! 1			Ва	ltimo	
· ·		6. Sex 7. A 1 X M 2 ☐ F	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of B	ay, Ye		Cour	
213-46-9 Usual Residence			60					Jan 20	, 1	947	Má	aryland
10a. State	10b. County	y	10c. City,	Town or Lo	cation						1	Od. Inside City Limit
Maryland	n	ı/a		R	altimore							1 X Yes 2 □ N
10e. Street and Nu		./ a		De	10f. Zip Code				100	Citizon of	What Cour	atru?
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4408 La	iriala	12. Was Decedent	Ever in ILS	13 \	Vas Decedent of Hi	_	in2 /Sno	oifu Voc or N			d Sta	
1 Never Man	ried 2□ Mai	Armed Forces	?	1.0.1	Was Decedent of His f Yes, specify Cuba	n, Mexican	, Puerto F	Rican, etc.)	0-		ck, White,	
3 Widowed	_	If Voc Givo		1	I∐Yes 2∭ZNo	Specify:				Specif	v: Wh	nite
	15. Decede	nt's Education		16a. Deced	lent's Usual Occupa	ition			16h	Kind of B	usiness/Inc	
(Spe	cify only highe	est grade completed)		(Give life. L	kind of work done d OO NOT use retired)	uring most	of workin	g	1		_311033/1(10	audi y
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17. Father's Name	(First, Middle							(First, Middle				
Anthor	ıv Pau1	. Urciolo						Annett			,	
19a. Informant's N	<u> </u>			19b. Mailin	g Address (Street a					v or Town	State 7	(Code)
		iolo/son										
20a. Method of Dis		1010/8011	20b. Plac	e of Dispos	Box 421 sition (Name of			West			City or To	
1 ☐ Burial 2		3 ☐Removal from State	сеп	netery, cren	natory or other place	· ;					•	
4 ☐ Donation 21. Signature of Fi			W . A		1 Cremato			2007	0d	enton	, Mar	cyland
	rita k	Thomas		Dc	Name and Address naldson I 11 Annapo	uner	al Ho	ome & Oden	Cres ton	mator , Mar	y, P. yland	A. I 21113
23a. Part Enter t	the disease, o	r complications that cause t only one cause on each li	d the death.							1102	7	Approximate
Immediate Cause	(Final											Interval Between Onset and Death
disease or condition resulting in death)	on	a. MULTIPL	a consequer									
		200 10 (6) 00	a consequer	100 01).								
Sequentially list coif any, leading to in	nditions, nmediate	b. Due to (or as	a consequer	nce of):							-	
Cause (Disease or	iniury	S										
that initiated events resulting in death)	Last	Due to (or as	a consequer	nce of):								
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IF FEMALE:		23c. If yes, outcome	v						23d. Date of delivery Month Day Year			
23b. Was deceden in the past 12	months?	23c. If yes, outcome 1□Live birth	2 Fetal de	eath 3 🗌	Ectopic pregnancy							ery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** P M 26 2007 Ester V. Wilburn /Medical 4c. County of Death Eacility Name (If not institution, give street and number) City, Town, or Location of Death Examiner itiZens 8. Date of Birth (Month, Day, Year) ge (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🛛 F 1924 82 9, Virginia Dec. Director 225-24-0692 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Rosedale Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. Α. 8329 Analee Avenue 21237 Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🎇 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Specify. 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be t Haalth and Mental I ဥ Coy Iron Myrtle Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S of Haalth Department of Haalth Important: If Item 27 any injury or other tronce. Sandy Wenski (Daughter) 707 Frans Drive, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify)Mausoleum Gardens of Faith 07/ 30/2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Fund al Service 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) menmon Ms **Physician** 8 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificata be exacuted burial-trar Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day for 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 2 No 3 Probably 4 Vunknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has to page 2 s autopsy performe certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 ne Hospital or Attending Pl n 24 hours after death. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

LETTERA

2

S. UNION AVE. HAVRE PE GRACE MD. 21078

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Time of Death 2. Date of Death WALKER **Physician** Month 011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NIa If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days 1 □ M 2 💢 F Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at BALTIMORE 1 Yes 2 No Director MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 385 21218 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or iten Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: BLK 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) , 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the M Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR of Health and Mental Hygie item 27 Is marked other other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be UNKNOWN WALKER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 389 ST. BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any Injury or once. METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillips him ai Nonit 21. Signature of Funeral Service Licensee 1721-27 N. Monine S. BALTIMORE, IND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Opset and Death Immediate Cause (Final metastate Ovarian concer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (bries a consequence of) Examiner The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s 2.XNo 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes 2 No Hospital: Other: 4 Nursing Home Certification: To 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence this 6 Other (Sp To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Mgnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130/N, Charlestreet Bultmore, MD 21212 31. Date filed (Month, Day, 32 Registrar's Signature Year State 0

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ruth Edna Walker 2001 11:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner Medical Center Burnie baltimore washington Anno Jun 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours -1□M 2□XF Director 227-56-3271 10/28/1945 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified of once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Warfield Road 21060 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. à Specify: Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Whitehead Willie Ruth Milteer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oliver Walker Jr. / Son 213 Warfield Road, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 08/06/2007 Baltimore, Maryland King Memorial Park 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21 Signature of Funeral Service Livense 4611 Park Hgts. Avenue, Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Puhonn **Physician** /Medical Due to (or as a consequance of): Examiner hastro in Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (Adeno carcinoma) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Mossine 2XNo 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of eath 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred <u>:</u> 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

leral Director; /
filled in by the fi Certificati 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Mys 200 ss of person who completed cause of death (Item 23a) (Type, Print 30. Name and addr

Registrar DHMH 17 Rev 1/2001

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32. Registrar's Signature

* 07-05799 Eric Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Eric Williams 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 29, 2007 0001 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County 2714 ClayBrooke Dr. Windspr Mill 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6 Sex Funeral Foreign Months Davs Hours Director 2.76.5687 Country) MID Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No or items 23a or 28a-f show must be notified at once. Baltimore Windser Mil Director 10g. Citizen of What Country? 10e. Street and Number USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Never Married 2 X Yes 2 Pages I and 2 should be filed within 72 hours; after tent of Health and Mdrial Hygiers, and ant: If item 27 is marked other than "natural", o and: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. s, Give Year 1 Yes 2 X No specify: Specify: Dlack 3 Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Technician 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Herman Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD aubrooke Drive. Windsur mill mo 21244 Oris Williams 20c. Location - City or Town, State Date Method of Disposition 20b. Place of Disposition (Name's timore, AT DOLLA Sher place) Removal from State Burial 2 Cremation Department of Important: I Baltimare. 08.03.200 Donation 5 Other Specify: me and Address of Facility Vaughn C. Greene funeral Service 21. Signature of Funeral Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart List only one cause on each line. Physician Between Onset and /Medical Death a Narcotic and alcohol intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical #23a,27,28a-f, perME,g870,8/22 TIEM/20b, perFH.0870.8/1/07.WS X UNPENDED X AMENDED attending physician or use as the burial the Hospital or Attending Physician: The law requires that the death certificate be a hin 24 hours after death. Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Month Year Ectopic pregnancy Live birth Fetal death 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of s certificate has b rector, page 2 sh death? performed? Yes 2 ~ 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other 4 Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 this I ER/Outpatient 3 1 Yes After the 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2 y No Pending Director: d in by the f FNd 7/28/2007 Fnd 11:53 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide 2714 Clay Brooke Dr. Baltimore, MD To the Funeral I (Specify) other-scene Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 29, 2007 O.C.M.E. 30. Name and address of person who completed cause of death) (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. egistrar's Signatur State 2007 Registrar OCME

Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f st	any Injury or other traumatic event, the Medical Examiner must be notified at	9000
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Funeral Director

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Examin		4h City Town or Location of Dooth								4c.	. County of	Death				
		Laurel Regional Hospital Laurel 5 Social Security Number 6 Sex 7 Age (In vis. last birthday) If Under 1 Year If Under 24						or Od Heo T			rince					
Funeral Director		5. Social Security N 577-36-7	327	6. Sex 1 ☐ M 2	7. Age (In yrs. last birthday) 80 Yrs.		Months Days	vs Hours Min.		8. Date of Birth (Month, Day, Yea May 5, 19		ear) 9. Birthplace (State Country) 927 West Virg		ace (State or Foreign try) Virginia	ח	
how		Usual Residence of 10a. State	10b. County			10c. City,	Town or Lo	cation						16	Od. Inside City Limits	
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Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ĀNever Marr 3 ☐ Widowed		ried Ari	ned Forces? Yes 2 4 es, Give ar or Dates:	lo	ver in U.S. 13. Was Decedent of If Yes, specify C		f Hispanic Origin? (Specify Youban, Mexican, Puerto Rican, o Specify:		Rican, etc.)	0-	Black, Specify: V	White, 6	etc.	
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und M		19a. Informant's Na	ame/Relations	hip (Type. Pri	int)		19b. Maili	ng Address (Street	and Nun	ber or Rura	l Route Numi	ber, City o	or Town, Sta	ate, Zip	Code)	_
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ysician		23a. Part 1. Enter the 1. Is se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h 1 fail ve. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of):														
Medical and physician and stree burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Sacral Decubitus Ulcer Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):														
within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2[9 ☐ Unknown	months?	1[4[ves, outcome Live birth Pregnant at Unknown	2 ☐ Fetal	death 3[⊒Ectopic pregnanc □ Other (specify) _	у				23d. Date o Month		ry Day Year	
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1		30. Name and add			6333 La	aurel	Bowi	e Road, S	Suite	208,	Laure	1, MI	D 2070	08		
Sta Registr		31. Date filed (Mon	AUG 0	2007	32. Registra	ar's Signat	yre	rates								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 July 30, 5:00 AM Thomas Joseph Weaver 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carrol1 3097 Lawndale Rd. Finksburg Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days Hours XXM 2□F 49 Yrs Sep. 20, 1957 Maryland 220-88-5272 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes XX No Finksburg MD Carrol1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21048 3097 Lawndale Rd. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes XXNo If Yes, Give Year or Dates: 1 Never Married XXMarried 1 □ Yes XXNo Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Concrete Elementary/Secondary (0-12) College (1-4or 5+) Concrete Foreman 12 Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olivia Merryman Ambrose Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3097 Lawndale Rd.; Finksburg, MD 21048 Patricia Weaver / Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place. Lakeview Memorial XIXBurial 2 Cremation 3 Removal from State 8/1/07 Sykesville, MD 4 Donation BO Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YCZ mostate disease or condition resulting in death) Du to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

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The law requires that the death certificate be executed

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To the Funeral I Hospital

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Division or Vital Records, P.O. Box 68760,

Physician

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Examiner

Funeral

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Is marked other than "naturaumatic event, the Medical a

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permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic even

Baltimore, Maryland 21215-0036

Director

Funeral

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Examine by Physician/Medical Completed s after death.

I Director: After this certification by the funeral director, p Be Certification: To

IF FEMALE: 25. Was case referred to medical examiner?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No

1 ☐ Yes 2 10 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be

determined

1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Other: 4 Nursing Home 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Residence 6 □Other (Specify)

28d. Describe how injury occurred

29a, Certifier (Check only one)

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

DOS7936 University or Manylord

07-30-2007

 O_I State Registrar

31. Date filed (Month, Day, Year) AUG 0 1 2007

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wannuel mo 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28 avonne M. Walker - Webb 2007 JU /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sinaittospital Bautimore Baltimore ot If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1□M 2 KF 217-94-8220 Director maryland Usual Residence of Decedent 10c. City, Town or Location f show 10b. County Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notifiled at Baltimore 1 Yes 2 □ No Director mi 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 301 Atholward
11. Marital Status 21229 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 Divorced Completed S 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Auditor Vear5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4304 Danicu Drive Baltimore MD 21007 Helen M. Walker Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadow Midge Midge 08:03, 2007 Elhridge MD 22. Name and Address of Facility Vaynn C. Green funcin Service 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Moad Mandaustan MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) piratory **Physician** Day /Medical Due to (or as a consequence of): Examiner SIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No After this certificate has funeral director, page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of eertifie 29d. Date signed (Month, Day, Year) Name and address of posson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, AUG 32. Registrar's Signature 284 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav 2010 M 2007 Hnderso Inte ances /Medical 4c. County of Death Facility Name (If not institution, give street and nu City, Town, or Location of Death Examiner Dorchester General MOSPITAL Dorchestei ambridge If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🔀 F Yrs **Director** 221-12-4334 86 Sept. 20 1920 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Dorchester Cambridge Director X⊓Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 208 Talbot Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 10. 1 Never Married 2 Married 1 ☐ Yes 2**%** No Specify white Maryland 21215-0036 Specify: Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 secretary social services 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe and Mental Willis Chandler Beard 1 and 2 should Martha Ellen Stevens ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 8 John Anderson son O. Box 345, Perryville, MD 21903 Important: If item 2 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State East New Market Cem. 7/19/07 4 □ Donation 5 □ Other (Specify) East New Market, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-t Box 68760 Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♣ No Month 4☐Pregnant at time of death 5 Other (specify) Ö the 9☐Unknown 9 Unknown þ ۵. signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 2 Probably 4 Unknown been sig 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an has page 2 autopsy performed certificate 1☐ Yes Division or Vital 2 **2** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar UGENE

ar's Signature

Cambridge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 14, 2007 Year **Physician** 4:00 P М Oliva Austria D. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Bradford Oaks Nursing & Rehab. Center 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year June 3, 1918 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 Days Hours 578-86-6293 Philippines Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland Waldorf Charles Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20603 2312 Knotweed Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 Married Filipino Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Be Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 4 College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Datuin Cavetano Lirisa Briones ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Austria / Son 10998 Alcorn Lane Waldorf, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 07/19/2007 1 X Burial 2 ☐ Cremation 3 ☐Removal from State permit. Page Department of Important: If any injury or \$t. Mary's Ch. Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatu of Funeral Service Licens 6160 Oxon Hill Road Oxon Hill, Maryland 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest flock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ♣ No 4□Pregnant at time of death 5 ☐ Other (specify) the a 9□Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autops, performed? autopsy this certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4K Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral Certification: After or Attending Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the tables of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as sated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

cf (2)

State Registrar 31. Date filed (Month, Day, Yéar)

JUL 1 8 2007

32. Registrar's Signature

07-05345 Kenneth Austin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nneth Austin		For State Control of Floating and Floating a	Reg. No.		7 21.62
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day	Year 3.	Time of Death 1846 hrs
edical Examin	er	Kenneth David Austin Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	July 8, 2007	c. County of Death	
	4	Johns Hopkins Bayview Medical Center Baltimore			
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	1.5	VDD/YYYY) 9. Birthp Foreign	
Director		214-94-0861 1XM 2F 41 Yrs.	12/09/1	965 Count	try) MD
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			0d. Inside City Limits
id how a	_	MD Baltimore Dundalk	LXMI		Yes 2 X No
4arylar 28a-f s 1 at on	Director	10e. Street and Number 10f. Zip Code	10g. Ci	tizen of What Countr	y?
ith the Maryland 23a or 28a-f show any notified at once.		219 Baltimore Avenue 21222 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp.	pecify Yes or No-	USA 14. Race - America	n Indian, Black,
ath wil	- T	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (A) If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	:+0
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21215-003 uld be filed withi Mental Hygiene, marked other th	Be	Kenneth David Austin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	S. Tones Rural Route Number,	City or Town, State, 2	Zip Code)
MD 21 d 2 should 1 th and Mer n 27 is man	우	Jackie S. Austin/Mother 140 Lakeview Drive, Le	eesburg, F	L 34788	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Interest 1 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State Modern Commentation Ju	ly 16,	c. Location - City or T	
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Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum		21. Super Juneral Service Licensee 22. Super Juneral Service Licensee 23. Name and Address of Eaclity Barranco & Sons, I 495 Ritchie Hwy, S	P.A. Sever	na Park Fi	uneral Home
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Medical	ð ú	failure. List only one cause on each line. Immediate Cause (Final disease a. Complications of Thermal Injuries			Death
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ruted nd ransit	Ë	events resulting in death). Last			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED X #28e-f. perMF. 2870, 8/3/07 TT		23d. Date of delivery	
3760, ificate be g physic s the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregions			ay Year
Box 6876(death certificate the attending phy ed for use as the b	sicial	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			1
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Divisior Hospital or Attend 24 hours after death is Funeral Director:	Certification:	4 Homicide determined (Specify) Residence State Park	219 Baltimore A		Flintstone, N
Division of Vital Rec within 24 hours after death. To the Funeral Director: After this certificate I To the Funeral Director: After this certificate I	ical		and due to the cause(sed at the time, date and	d place, and due to the	ne cause(s)
To the within To the countle	Medical	and manner stated. 29c. License number		29d. Date signed (Mo	
		h Carde Hallan O.C.M.E.	,	July 13, 2007	
ON	BI	30. Name and address of person who completed cause of death (Item 23a)	201		
N	7	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21. 31. Date filed (Month, Day, Year) 32. Refistrar's Signature	<u>-</u> U1		
Regi	State stra	titi 1 7 / lill / 1 Tradical a Ch. Company			

07-05699

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Enrique Acosta	State of Maryland / Department of Health an 1-For State Certificate of Death	
Dhysician	Registrar	Reg. No. 2. Date of Death 3. Time of Death
Physician/ Medical Examiner		July 25, 2007 Year 0747 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or	or Location of Death 4c. County of Death Cecil
•	2200 Block Appleton Road Elkton	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea	Foreign
Director	187-62-9087 1 x M 2 F 25 Yrs.	January 18,1982 DE
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
l low any	MD Cecil Elkton	1 Yes 2 X No
rylanc in one ctor	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
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death with the Maryland death with the Maryland re items 23a or 28a-f she must be notified at once runeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of H	iispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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5-0036 ed within 72 hour lygiene other than "natte he Medical Exan Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica Be Comple	Enrique Acosta, Jr.	Deborah D. Acosta
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nant of Health and Montal Hygiene fant: If friend 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Toda information realistics (177)	reet and Number or Rural Route Number, City or Town, State, Zip Code)
MD nd 2 sho alth and alth and m 27 is raumati	Enrique Acosta, Jr./Father 128 Brook	kside Blvd, Newark, DE 19713 cemetery, Date 20c. Location - City or Town, State
Baltimore, cernit Pages I an Department of Hee Important: If the	1 Burial 2 X Cremation 3 Removal from State crematory or other place)	July 28, Hast Charter DA
Fag ment tant:	4 Donation 5 Other Specify: R.A. Ferris I	2007
Baltimore, ME permit Pages I and 2 bearment of Health a Important: friem 27 injury or other traum	Andrew	G. Gee Funeral Home
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin	ng, such as cardiac or respiratory affect, Shock, or heart Between Onset and
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Mixed drug intoxication (alprazola)	Dogth
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	Sequentially list conditions, b. Due to for as a consequence of j.	
	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
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Of Vital Records, ing Physician: The law required this certificate has been surred director, page 2 should I	26 Pig	lace of Death (Check only one)
Vita ysicia	by Was case referred to medical examiner? Description: 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing Home 5 Residence 6 Other: Scene
	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. In	Injury at Work? 28d. Describe how injury occurred
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Spital Spital hours neral	4 Homicide determined (Specify) found on street 29a. Certifier 1 Continue Physician: To the best of my knowledge death occurred at the time	
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director A completely filled in by the funeral presence of the forms of the funeral director and the function of	29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin	nion, death occurred at the time, date and place, and due to the cause(s)
To t Com	and manner stated.	cense number 29d. Date signed (Month, Day, Year)
	All houself Mix	.C.M.E. July 26, 2007
	30. Name and address of person who completed cause of death (Item 23a)	
	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street	t, Baltimore, MD 21201
Sta	PLUID V I CUUI 27/9×2···· III // //AMARARA II	
Registr	ar Journal of the second	
DHMH 17 Rev 1/200	ORIGINAL	

07-05625

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Robert P Brauns 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 22, 2007 1647 hrs Medical Examiner Robert P Brauns 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Severna Park 108 Hatton Drive If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Oreign Maryland Months Davs Hours 03/05/1953 Director 217-58-0407 1 X M 2 54 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location ynt 10a. State Yes 2 X No items 23a or 28a-f show Anne Arundel Severna Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 108 Hatton Drive 21146 USA 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' Never Married Married 2X No Yes Yes 2 X No specify: Specify: White If Yes, Give Year hours after Widowed 4 X Divorced Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. ò 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 Coca-Cola Company 2 Truck Driver 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be William Paul Brauns Gertrude L. Stinchcomb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Itimore, MD 108 Hatton Drive, Severna Park, Maryland 21146 Gertrude L. Hall/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition July 27, crematory or other place) X Burial 2 Cremation 3 Removal from State Elkridge, MD Meadowridge Memorial 2007 Important: injury or ot Donation 5 Other Specify 22. Name and Address of Facility al Service Licenses Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, Severna Severna 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and Death Indical Atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Litter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and Physician/Medical g physician a the burial -X UNPENDED #23a,27,perME,g870, 8/8/07 TI Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Ectopic pregnancy Month Day attending p Live hirth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) After this certificate has been signed by the att funeral director, page 2 should be detached for 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. No 3 Probably 4 V Unknown Þ Yes 2 Completed 24a. Was an 24b. Were autopsy findings available pnor to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other, Hospital: 1 Residence 6 Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 No 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 1 X Natural Yes 2 Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide filled determined To the Funeraf Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 23, 2007 O.C.M.E. Noma moincenti, M.D. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner istrar's Signature 31. Date filed (Month, Day, Year)

Registrar

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

e disease, or co t failure. List on	implications the caused the death. Do not enter the ly one cause on each line.	e mode of dying, such as cardiad	or respiratory arrest,	Approximate Interval Between Onset and Death
Fin <i>a</i> l	CAROLO DUMONATU	DARRELT		Offset and Death
4	Due to (or as a consequence of):			
ditions	MAL NUTRETEUN. / E	ilecticity te Distubri	te.	minuter.
ditions, mediate tying	Due to (or as a consequence of).			
njury	MULTE ENFARCT D	emeuter		DAYS.
ast	Due to (or as a consequence of):			
pregnant	23c. If yes, outcome pf pregnancy		23d.	Date of delivery
nonths?		opic pregnancy eer (specify)		Month Day Year
eant conditions	s contributing to death but not resulting in the underl NOL Acutic Answryms	ying cause given in Part I.	23e. Did tobacco use c	contribute to the cause of death?
	cd Disense.		24a. Was an autopsy performed? 1 Yes 2 No	4b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ed to medical	Harris and		th (Check only one)	
0	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4☐ Nursing H	ome 5 Residence 6 🗆	Other (Specify)
5 □ Pending investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury oc	curred
6 Could not determine		actory, office	28f. Location (Street and Nu City or Town, State)	umber or Rural Route Number,
Certifying	Physician: To the best of my knowledge, death occ aminer: Op the basis of examination and/or investi and manner stated.	curred at the time, date and place gation, in my opinion, death occu	e, and due to the cause(s) and arred at the time, date and pla	I manner as stated. ce, and due to the cause(s)
the of certifie	del ws.	29c. License number 50707		gned (Month, Day, Year)
ss of person wh	o completed cause of death (Item 23a) (Type, Print)		
Eng	1502 S. Main St., Su	uite 202 Mt.	Airy, MD 2177	71
, Day, Year)	22 Pagistraria Cignotura			
0 1 20	07 April 15 April	,		

3. Time of Death

4:00A

10d. Inside City Limits 1 ☐ Yes 2X No

Birthplace (State or Foreign Country)

Maryland

White

or Attending Physician: After death.

To the Hospital within 24 hours a

To the Funeral I

completely filled

þ

Completed

Be

Certification: To

Medical

25. Was case referred to medical examiner?

Samuel Eng 31. Date filed (Month, Day, Year)

1 ☐ Yes 2 No

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only 29b. Signature and

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. The df Death **Physician** 10 = 51 00 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 150 WICOM OASTAL LISBUR If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖫 F Hours 5/3/1914 221-09-6506 93 Delaware Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural;" or Items 23a or 28a-f show any Injury or other traumatic event, the Medi-al Examiner must be notified at any Injury or other traumatic event, the Medi-al 1 ☐ Yes 2 ☐ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1813 Mt. Hermon Road 21804 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No white ģ Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Adkins Viola LeCates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Debbie White/granddaughter 7678 Gumboro Rd., Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) St. Stephens Cemetery 6/21/07 Delmar, DE 21. Signature of Funeral Service Lenses 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Head and No /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or de a consequence of) Examiner that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-Box 68760. Physician/Medical as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 NO 1 ☐ Yes 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 20 NO 1 ☐ Yes 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No Inpatient 2 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P safter death. Certification: Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) augh. 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1 - State Registrar	State of Marylar			f Health and of Death	d Mental Hy	giene Reg. No.	21111	24631
	.		1. Decedent's Name (First, Middle, Last,					2. Date of De	aath Day	Year	3. Time of Death
	Physicia /Medic		James Thomas	Beavers				July	26		7 12:45 A ^M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Tov	m, or Location of De	eath		County of Death	
		2	St. Mary's Hosp 5. Social Security Number 6. Sec		last birthday)		rdtown	Irs. 8. Date of Bir		. Mary	
	Funeral Director			2M 2□F 74	Yrs.			lin. (Month, Da	ay, Year)	Col	nplece (State or Foreign untry)
7			Usuet Residence of Decedent					12/14/	1932	wası	ington, DC
200	how		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
N o	86-1	Directo	Maryland St. Mary	's Av	enue						1 □ Yes 2 No
4	De Co		10e. Street and Number			10f. Zip Co			-	zen of What Coi	•
4	10 234	Funeral	38696 Thomas Cour	t 12. Was Decedent Ever in U	10 12	206		/Coordy Von or No		ed Stat	
100	iten i	Į.	11. Marital Status 1 ☐ Never Married 2t☐ Married	Armed Forces?		If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pu	erto Rican, etc.)	-	Black, White	
	ei, o	þ	3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2🌠	No Specify:			Specify: Wh	nite
ה ה	natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual O	ccupation	working	16b. Kii	nd of Business/1	ndustry
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	ntal F ed ot	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle		Sumame)	
	d Me mark matic	ဥ	John Edward Beave		19h Maiti	na Address /Si	reet and Number or	ne Emma R		r Town State 7	in Code)
3	Ith and Ith an		Joanne Beavers/ W				Court, A				
a	perfilt. Tages I allo a subout belief within 2 frous area deet with the way and perfilt. Tages I allo a subout belief and Mental Hygiene important: if item 27 is marked other than "naturel", or items 23s or 28e-f show any injury or other treumatic event, if a Medical Examinar must be notified at 900s.		20a. Method of Disposition	20b	Place of Dispo	sition /Name o	of.	Date		cation - City or	
	nt: if		1 Burial 2 □ Cremation 3 □ F Donation 5 □ Other (Specify)	Removat from State Che	sapeak	^{matory} or othe e Highl Park	and	/30/2007	Port	Ropub 1	ic, Maryland
	Departm Departm Imports any inju		21. Signature of Funerat Service Licens		22	2. Name and A	ddress of Facility	Srinsfiel	d Fur	neral Ho	me. P A
0 8	20 = 20		Kyle S. Simons	M01 206	22	2955 Ho	llywood R	oad, Leor	nardt	own, Ma	ryland_20650
			23a. Pert1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the dea ne cause on each line.	th. Do not en	ter the mode of	dying, such as care	diac or respiratory a	rrest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	PNEUN	DONIF	7					Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a conse	quence of):	CILLAR	ACC	IDENT	-		
		_	Sequentially list conditions,								
Pot	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	M	YELDI	D LEU	KEMIA			
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0	ng ph	Med	IF FEMALE:								
XOC.	ttendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		⊒Ectopic pregr	ancy		1	23d. Date of deli Month	very Day Year
0. n	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5[Other (specif	y)			WORL	Day
· 2	ed by detac		Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying caus	e given in Part I.	23e, Did	tobacco u	ise contribute to	the cause of death?
ords, r.O	been signed by the attending p should be detached for use as:	d by		•	•	, , ,			Yes 2		
	shou	Completed						24a. Was	s an	24h Were au	tonsy findings available
The fact	e hes	E						- auto	psy ormed2	death?	topsy findings available comptetion of cause of
0	rtifice tor, p	0	25. Was case reterred to medical				26. Place of I	1 ☐ Yes Death (Check only		1 Yes	2 No
> 1	direc	To B	examiner? 1 Tes 2 No	Hospitat: 1 Inpatient 2] ER/Outpatier	nt 3 DOA	Othor	g Home 5 ☐ Res		6 □Other (Spec	cify)
0 8	Atter the		27. Manper of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c.	Injury at Work?	28d. Describe	how infur	y occurred	
200	tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No				
DIVISION	Direc Direc in by	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st ify)	reet, tactory, of	fice	28f. Location (City or To	(Street an wn, State	d Number or Ru)	ral Route Number,
ا الماردة	ours ours ours dilled		29a. Certifier 1 Certifying Phy	sician: To the best of my kn	nowledge deat	h occurred at t	ne time, date and of	ace, and due to the	Cause/s)	and manner as	stated
3	within 24 hours after death. To the Funerell Director; After this certificate hes completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Exami	ner: On the basis of examinand manner stated.	ation and/or in	vestigation, in	my opinion, death o	ccurred at the time.	, date and	place, and due	to the cause(s)
4	withir To the	M	29b. Signature and title of certified og			29c. Li	cense number	ad		e signed (Monti	
N			A GHOW A			D	00593	010	ل نىلا	7,26	, 2007
P	1		30. Name and address of person who o								
	7		Dr. Alok Rustogi	M.D., 25500		Lookou	t Road, L	eonardtow	m, M	aryland	20650
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Sign	400	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 25 2007 A^{M} Agnes Cecilia Oliver Brown Ju₁y 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 87 225-18-4688 Director 1919 Virginia 9, Sept. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21585 Peabody Street Funeral 20650 United States Pages 1 and 2 should be filed within 72 hours after death Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Payroll Clerk Administrative th and Mental Hygie 7 is marked other the permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert W. Oliver Mary Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Dunn / Daughter 95 Jacobs Ln., Fredericksburg, Virginia 22406 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Hill Cemetery 07/28/2007 Fredericksburg, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home PA. M01206 22955 Hollywood Rd. Leonardtown, Maryland 20650 Kyle S. Simons 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mathematical mathematical examiners stated.

State Registrar

Year)

erson who completed ca

M.D.

use of death (Item 23a) (Type, Print)

within 2.

29b. Signature and title of dertifier

30. Name and address of

James

Ρ.

31. Date filed (Month, Day)

JUL 26

Janboe,

29c. License number

24035 Three Notch Rd., Hollywood, Maryland 20636

29d. Date signed (Month, Day, Year)

		For State		State	of Maryla		partment of			ental Hy	ygiene)		
Si.		Registrar 1. Decedent's Nam	no (Eiret Middle	(net)		Ce	ertificate of	Death		2. Date of D	Reg. No.	201	17	3. Time of Death
Physicia	an									Month	Day		ar	
/Medic Examin	0.00	Phyllis 4a. Facility Name (umber)		4b. City, Town,	or Location of	of Death	J uly	18 4c.	, 200 County of D	·	7:00 p.m.
Lxaiiiii	ÇI Se	Ravenwood	d Luther	ran Villa	age		Hagers	town			W	ashing	ton	
Funeral		5. Social Security I		6. Sex 1 ☐ M 2 🖫 F		rs. last birthda	y) If Under 1 Year Months Days		24 Hrs. 8	B. Date of Bi (Month, D	irth Day, Year)	9. [e (State or Foreign
Director		219-14-7 Usual Residence of		ILIW ZULF	80) Yrs.				Aug. 2	26, 1	926	Penn	sylvania
land ow		10a. State	10b. County		10c.	City, Town or	Location						10d.	Inside City Limits
Mary a-f sh	tor	Maryland	Wash	ington		Hager	stown							1 ☐ Yes 2 X No
th the or 28a e not	Sire	10e. Street and Nu		-			10f. Zip Code				10g. Citi	izen of What	Country?	?
ath w	ral	12845 F	Resh Roa					21740				USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Mar 3 ☑ Widowed	rried 2 Marri 4 Divorced	Armed I	a 2 ⊠ No Bive	U.S. 13	8. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☒ No	ban, Mexicar	n, Puerto Ri	ify Yes or N ican, etc.)	lo-	14. Race - A Black, W Specify:	hite, etc.	
72 hou natura Jical E	Completed	(Spe	15. Decedent	's Education t grade completed	d)	16a. Dec	edent's Usual Occu	upation e during mos	st of working	7	16b. Ki	ind of Busine	ss/Indust	try
vithin ne. han "	mple	Elementary/Sec			(1-4or 5+)		ve kind of work done . DO NOT use retire cmaker	ed)	n or worning	,	1	her ow	n ha	
filed w Hygie ther t		11 17. Father's Name	e (First, Middle, i	Last)	0	1101116	Illakei	18. Mothe	er's Name /	First, Middle			11 110	me
ld be lental ked o	To Be		1. Younk							1 Ham				
shou and M s mar umat	-	19a. Informant's N	Name/Relationsh	nip (Type. Print)		19b. Ma	iling Address (Stree	et and Numbe	er or Rural	Route Num	ber, City o	or Town, State	e, Zip Co	nde)
and 2 salth a n 27 is		Carole W	Volfensb	erger -d			Sunbrool		, Hag	ersto	wn, N	Maryla:	nd 2	1742
ges 1 t of He if item or oth		20a. Method of Dis	•	3 □Removal from	n State I		position (Name of rematory or other pl		Da			ocation - City		
t. Pag rtmen rtant: njury		4 □Donation	5 ☐ Other (Sp	pecify)			Lawn Mem.	- :	7/23/		1		-	aryland
permi Depa Impo any Ir		21. Signature of F	aneral Service)uni		9 2. Name and Addr 415 E. W:							17/0
t Carrier		23a. Part1. Enter	the disease, or	complications that	t caused the de	eath. Do not e	nter the mode of dy					own, M	Ar	1740 pproximate iterval Between
Physician		Immediate Cause disease or condition	(Final	only one cause on	each line.	adie	canel	A) 11	uka	um	00	1 mes	Or	nset and Death
/Medical		resulting in death))	Due to	o (or as a cons	equence of):	Junio	· ·	001-0	0071	1	-	1-1	1760100
Examiner		Sequentially list or	onditions.	b										
bed usit	Examiner	Sequentially list or if any, leading to li- cause. Enter Und Cause (Disease of that initiated event	mmediate lerlying or injury	Due to	o (or as a cons	equence of).								
icate be executed physician and the burial-transit	xar	that initiated event resulting in death)	ts Last	c Due to	o (or as a cons	equence of):							-	
re be ysicial e buri	dical			d										
் 🛱 நெல்	Medi	IF FEMALE:												
To the Hospital or Attending Physician: The law requires that the death certifications after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live blirth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year				ıy Year	
s that ned b	by Pł	Part II. Other sign	ificant conditio	ns contributing to	death but not r	resulting in the	underlying cause g	iven in Part I	l.	23e. Did	l tobacco ι	use contribute	e to the c	cause of death?
equire en sig vuld b										10	Yes 2	□ No 3□	Probabl	ly Unknown
The law re ate has be page 2 sho	Completed									24a. Wa: auto peri 1 Yes	opsy formed?	prior death	to comple	/ findings available letion of cause of
iclan: certific ector,	Be	25. Was case refe examiner?		Hospital:			10		e of Death (Check only	one)			
Phys	٠ <u>.</u>	1 ☐ Yes 200] No ath	<u>'L</u>	Inpatient 2	ER/Outpati	ent 3 DOA			e 5□Res 8d. Describe		6 Other (S	Specify)	
ding th. : After	Certification:	Natural 2 Accident	5 ☐ Pending investig) (Mo	onth, Day Year		/ We	ork? □Yes 2□		d. Describe	s now inju	ry occurred		
After r deal ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n	ot be 28e. Pla	ce of injury - A	t home, farm,	street, factory, office	е	28	Bf. Location	(Street an	nd Number or	Rural R	loute Number,
tal or rs afte al Dir ed in	Cert	4 🔲 i lonnoide	_	Dui	airig, etc. (ope	ony)			, t	City of Te	own, State	3)		
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier (Check only one)	2 Medical I	Examiner: On the	basis of exam	ination and/or	ath occurred at the investigation, in my	opinion, dea	ath occurre	d at the time	e, date and	d place, and	due to th	e cause(s)
with To com	2	29b. Signature and	Q/1 404	191	hal	_	29c. Licer	nse number	£26		29d. Da	te signed (M	onth, Day	y, Year)
		00 No.	- uju	1-11		tom 60-1 (T	- Driet	12	70 76	7	11-	-19	-0	/
54-10		30. Name and add	ZAR.	O S E	HAPI.	368 2	29c. Licer e, Print) Well Sti	red-	Hag	estar	ure	10217	740.	
Sta Registr		S. Dato mod (Mo	JUL 2 (2007	Care	A. 1	but							

	•	State of Maryland / Department of Health State of Maryland / Department of Health Certificate of Deat			jiene leg. No. 🔧	0 17	0100
Physicia	ın	1. Decedent's Name (First, Middle, Last) Earle Stanwood Bagley, Jr.		2. Date of Dea July 15,	th Pay 2007	Year	3. Time of Death 11:55A M
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location Upper Marlboro			4c. Count	y of Death George	
Funeral Director		0027 07 00001110 110000	der 24 Hrs.	8. Date of Birth Month, Day June 2,		9. Birthpl	ace (State or Foreign
Maryland -f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George Upper Marlboro				10	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
with the	Direc	10e. Street and Number 6327 S. Osborne Road 20772			10g. Citizen of	What Coun	try?
BAITIMOYE, IMBRYIANG 21213-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hydiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show amy fujury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1969 1 Yes, Give 1973 1 Yes 2 No Spec		ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americack, White, White	etc.
IZ I 5-UU36 within 72 hours af sne. than "natural", or	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during in life. DO NOT use retired) CON Nat. Railroad Pass		1	16b. Kind of E		lustry
yland Z Juld be filed v Mental Hygie arked other t atic event, tb	To Be Co	17. Father's Name (First, Middle, Last) 18. Mo		(First, Middle,	Maiden Surna	me)	
Mary and 2 shoulalth and Mary 27 is mailth art traumail	Ī	19a. Informant's Name/Relationship (Type. Print) Nancy A. Bagley/ Wife 19b. Mailing Address (Street and Number 19b) 19c. Mailing Address (Street and Number 1					Code)
Saltimore, bernit. Pages 1 a Department of Hee mportant: If Item any Injury or othe		20a. Method of Disposition 1 Burial 2 Decreation 3 Removal from State 4 Donation 6 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory	7/17	/2007	20c. Location Edgewat	er, M	wn, State laryland
Dant. permit. Departr Importa any Inj.		21. Signature Funeral Service Licensee 22. Name and Address of Fa 6160 Oxon Hill Rd	d. Oxon	Hill, Md	20745	Home	
Physician /Medical Examiner	8 1	23a Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma Due to (or as a consequence of):	meta	or respiratory ar	rest,		Approximate Interval Between Onset and Death
b8 / bU, ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Duc to (or as a consequence of): C. Due to (or as a consequence of):					
death certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				ate of delive	ery Day Year
COTGS, P.O. **requires that the defense signed by the should be detached.	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P.	Part I.	23e. Did to			ne cause of death?
VITAI HECONGS, sician: The law requires the certificate has been signe irector, page 2 should be con	Completed			24a. Was autor perfo 1□ Yes	osy ormed?	prior to co death?	psy findings available mpletion of cause of 2□ No
VISION OF VITAI RECORDS, P.O. Attending Physician: The law requires that the relative. Cleath. ector: After this certificate has been signed by the tuneral director, page 2 should be detached.	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 C 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Word?		th Check onl of the come 5 A Residence 28d. Describe	dence 6 □C		ýy)
JIVISION OF I or Attending Physafter death. Director: After this lin by the funeral di	Certification:	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work: 2 ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	2□No	28f. Location (City or To		nber or Run	al Route Number,
DIVISIC To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the f	Medical Ce	29a. Certifier (Check only one) 1 ertifying Physician: To the best of my knowledge, death occurred at the time, dat 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	ate and place, n, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as s e, and due i	stated. o the cause(s)
To the within 7 To the comple	Mec	29b. Signature and title of certifier 29c. License numb		19	29d. Date sign		- '
R (12)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Carducci, M.D. 401 North Broad	dway	Belt	merc	4N 7	1231
Sta	ate	Michael A. Carclucci, M.D. 401 Porth Broad 31. Date filed (Month, Day Year) 32. Registrar's Signature 32. Registrar's Signature	1	3-10/1/	-10/4/	ع رن	<u>-</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ammend line #18 State of Maryland / Department of Health and Mental Hygiene CCHD 7/24/07 For State Registrar Certificate of Death **KDS** 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 3:27PM 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner UNWERSITY BALTIMORE macyland MORIOR Cox Co Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 30 5. Social Security Number 6. Se: 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Country) Maryland 1 XM 2 ☐ F 212-31-9222 1986 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 Is marked other than "natural", or Items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Calvert Chesapeake Beach Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3812 27th Street 20732 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Completed by Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 of Health and Mental Hygiene. Item 27 Is marked other than College (1-4or 5+) screen printer retail clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Thomas Guy Brown Karen-Lynn Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Lutie Street, Nashville, TN Karen L. Bryan, mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Southern Mem. Grdns 107-18-2007 Dunkirk, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home PA, PO Box 100 Owings MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Por in the past 12 months? Dav 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 HO 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has e 2 autopsy prior to com death? page DRUG perform USF certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 일 2□ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day uneral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH STROET 31. Date filed (Month, Day, Year) 32. Registras Signature State 2007 ▶ 16 Registrar

Amend #9,per FD, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Washington, D.C., State of Maryland / Department of Health and Mental Hygiene 7/16/07, drw For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mabel Mackall Briscoe 8:30 A. 2007 July 13, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4265 Tupelo Court Port Republic Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F 88 2 1918 Director <u>578-12-7338</u> Aug hington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Calvert Port Republic Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4265 Tupelo Court 20676 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Medical Examiner morrest once. by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**o Specify. white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CPA Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Bourne Mackall Mary Evelyn Parran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Burke- POA/Executor 4035 Shamrock Ct. Port Republic MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place)
Christ Episcopal Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Removal from State 2007 4 □ Donation 5 □ Other (Specify) Port Republic Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 9 4405 Broomes Is. rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Ten yeur Rulmonary Obstructive **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to [or as a consequence of] cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2★ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

25156

Ukules Bennett M.O 29c. License number 29d. Date signed (Month, Day, Year)

July 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles W. Bennett, MD 11845 H. G. Trueman Rd., Lusby, Maryland 20657

State Registrar

Certification:

Medical

32. Registra Signature 31. Date filed (Month, Day, Year) 1 6 2007 JUL

State of Maryland / Department of Health and Mental Hygiene

sniey Marie Be	BIIUS	State of Maryland / Departmen 1-For State Certificate Registrar				Ment	al Hy		g. No	201	17 2463
Physici ledical Exami		Decedent's Name (First, Middle,Last)					2	2. Date of Deat Month	h Day	Year	3. Time of Death 2142 hrs
edical Exami	IIIÇI	Ashley Marie Bellosi 4a. Facility Name (if not institution, give street and number)	<u> </u>	b. City, T	own, or L	ocation of	f Death	July 11, 20		c. County of Deatl	
		University Hospital		Baltim							/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 219–08–5953 1 M 2X F 23	ay) Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Date of Birt Jun 1	`	/DD/YYYY) 9. Bir Forely 1984 Co	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	on							10d. Inside City Limits
Aaryland 28a-f show 1 at once.	5	MD Calvert Huntin	gto	wn							1 Yes 2 X No
n the Maryland 3a or 28a-f sho	Director	10e. Street and Number 100 Hoile Lane		10f. Zip		0639		10	0g. Cit	izen of What Cou USA	ntry?
with the mas 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was	Decede	nt of Hisp	anic Ongi	n? (Spe	afy Yes or No-		14. Race - Amer	can Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygier than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once, injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced Iff Yes, Give Year		Yes 2			Puerto R	ican, etc.)		White, etc. Specify:	White
nours af natural xamin	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	cedent	's Usual (Occupation		ind of wo	rk done	16b.	Kind of Business/	industry
136 hin 72 l e. than ",	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	-	etol	_		130 101110	σ,		Beauty SI	non
5-00 led with Hygien other		17. Father's Name (First, Middle, Last)					Name (I	First, Middle, M			<u> </u>
2121 uld be fi Mental marked event,	To Be	John Bellosi 19a. Informant's Name/Relationship (Type, Print) 19b. N	/ailing	Address	(Street	Susa		ral Route Num	her C	Leak	Derry Zin Code)
MD 3	-	John Bellosi (father) 100	ОН	oile	Lane	e Hu	ıntir	ngtown,			, Zip Gode)
Ore, es l an of Heal If iten		20a. Method of Disposition 20b. Place of Disposition Removal from State 20b. Place of Disposition Removal from State	or oth	er place)			July		20c.	Location - City or	Town, State
Itim ii. Pag artment ortant:		4 Donation 5 Other Specify: Resurre				tery of Facility		007		inton, M	D vert, PA
Ba Pem Dep Imp	ę J	Justy / Syff	81:	25 S	outhe	ern M	lary1	and Bl	vd.	Owings	
Physician /Medical	18	23a. Part. Enter the disease, or complications that caused the death. Do not en failure. List only one cause de each line.		e mode o	f dying, s	uch as ca	rdiac or r	espiratory arre	est, sh	ock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Blunt force trauma to the head Due to (or as a consequence of):	_								Death
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	_	_							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
secuted 1 and - transit		d									
60, nte be ex hysician e burial	Medical	UNPENDED X AMENDED #20b, perFH, G872, 10/ IF FEMALE: 23c. If yes, outcome of pregnancy	<u>′2/0</u>	7 TT					Tas	d. Date of deliver	
Box 68761 death certificate the attending phy		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day									
Box e death the atter ed for u	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown 5	Oth	er (Spec	ify)		•				
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transi	by	Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying	cause giv	en in Par	t I.		-	use contribute to No 3 Prot	the cause of death?
Division of Vital Records, rate der Attending Physician: The law requirant dere death has been so I birector: After this certificate has been seled in by the funeral director, page 2 should I	Completed							24a. Was a	sy	prior to o	topsy findings available ompletion of cause of
tal Rec	Com							perform 1 ✓ Yes 2		death?	s 2 No
Vital hysician: this certif	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpa	atient		10	f Death (C			Reside	ence 6 Other	
n of Jing Ph After t funeral	on: To	27. Manner of Death 28a. Date of Injury 28b. Tim 50 (Mg/th), Day, Year) 50 (INIT		jury 2		at Work?	Is	8d. Describe h ubject beat		ury occurred	
iSiol	icati	2 Accident Investigation Jul 7, 2007 0346 hr	rs	, factory,		s 2 🗸 l	NO			and Number or Ru	ral Route Number, City
Div spital or ours aft teral Di	Certification:	4 Momicide Could not be determined (Specify) Home								, Baltimore , MI	
Division of Division of To the Hospital or Attending Phwithin 24 hours after death To the Funeral Director: After templetely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) Medical Examiner: On the basis of examination and/or investigation.									
To with Con	Mec	and manner stated. 29b. Signature and title of certifier		29c.	License	number			29d.	Date signed (Mo	nth, Day, Year)
		Calacet !			O.C.M	.E.			July	/ 12, 2007	
5		Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111	Penr	Street	, Baltin	nore, M	D 2120	01			
St	ate	31. Date filed (Months Rey, Year) y 2007 32. Figistrar's Signature	A.	- M a							

		•	For State Registrar		,	Cei	rtificate of	Death		Re	eg. No.	11/	26	538
	Physici	an	1. Decedent's Name (First, Midd							Date of Deat Month	th Day	Year	3. Time of	Death
4	/Medic	al	Josephine An				41. 07. 7			ıly	14 2	007	9:30	РМ
	Examin	er	4a. Facility Name (If not institution Marley Neck	-		4b. City, Town, or Location of Death Glen Burnie 4c. County of Death Anne Arundel								
	Funeral Director	- 10	5. Social Security Number 092–12–6275	6. Sex 7. A	ge (In yrs. lasi 85	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. 1 Min. Ju	Date of Birth Month, Day, 11y 10	Year) 1922	9. Birthp Cour New	place (State of try) York	r Foreign
	land bw		Usual Residence of Decedent 10a. State 10b. Count	y	10c. City, T	Town or Lo	cation	eation 10d. Inside City Limi						
	Maryl -f sho fied a	ţ	MD Anne	Arundel	Glen	Bur	nie						1 🗌 Yes	2 No
	n the	irec	10e. Street and Number				10f. Zip Code			1	0g. Citizen of \	What Cou	ntry?	
	th wit 23a c 1st be	alD	7575 E. Howard	d Road			21060				USA			
	er dea tems	nue	11. Marital Status	12. Was Deceden Armed Forces	?	13.	Was Decedent of I	Hispanic Original	gin? (Specify , Puerto Rica	Yes or No- in, etc.)		e - Americ	an Indian, etc.	
9036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	No :		1□Yes 2 X No	Specify:			Specify		ite	
5	"natu	etec		ent's Education lest grade completed)	1	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	t of working	11	16b. Kind of B		•	
7	within ene. than he Me	To Be Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		reelance				Journ	nalis	m	
0	filled Hygi other ent, tl	ပ္မ	17. Father's Name (First, Middle	e, Last)						rst, Middle, N	Maiden Surnan	ne)		
<u>la</u> n	uld be Aental rked c	O B	Owen Inserra	L				Marg	garet B	Rizza				
ary	2 should and Nickell should be made and		19a. Informant's Name/Relation			, City or Town,		,						
≥	and health		Mark Francis C	279 Lower Magothy Beach Rd., Severna Park, MD							46			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (cem	lace of Disposition (Name of emetery, crematory or other place) ro Crematory 07 947/07 20c. Location - City or Town, S Baltimore, MD								
alti	ermit. epartn nports ny Inju		21. Signature of Funeral Service	e Mounsee	·	E	2. Name and Addre	ess of Facility	P.A.	Sever	na Parl	k Fun	eral H	Iome
	20 E 8 9	4	MICO	Jason	Xo	40	5_Gov. R	itchie	e Hwy.	Sever	na Parl		21146	5
		A		st only one cause on each	line.		er the mode of dyi	ng, such as	cardiac or res	spiratory arre	est,	1	Approximat Interval Bet Onset and I	e ween Death
	Physician /Medical		Immeriate Cause (Final discusse or condition resulting in death)	a	ediac		myla	nla						
	Examiner	$\overline{}$		Due to (or as	s a consequer	ice of):	4							
		je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequer	nce of):								
	ecuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с										
,60,	rtificate be executed ng physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as	s a consequer	nce of):								
68760	ificate g phys as the	Medical		d							-			
. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant	e pf pregnanc 2 □ Fetal de at time of deat	eath 3[⊒Ectopic pregnand ⊒Other <i>(specify)</i> _	у				te of deliv		Year
P. O.	at the i by th stache	Phys	9 ☐ Unknown	9LJUnknown										
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eco	law re nas bee	Completed	Deulis							24a. Was a	n 24b.	Were auto	psy findings mpletion of c	available ause of
a H	t: The icate l									perform 1 Yes	med?	death? 1 ☐ Yes	2 No	
=	slciar certif	Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	tient 2□ER)/Outnotion	oti Oti	her:	of Death (CI					
0	g Phy er this eral d	.: 10	27. Manner of Death	28a. Date of In	jury 28	8b. Time o	IL 3 DOA	4 El Nu			ence 6 □Oth ow injury occur		fy)	
<u>o</u>	ath. or: Afte	atio	1 Natural 5 Pend 2 Accident inves	ling (Month, D stigation	ay Year)	Injury		rk?]Yes 2∐≀	No					
<u>N</u>	or Atte ter de: lirecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 28e. Place of It	njury - At home etc. (Specify)	e, farm, sti	eet, factory, office		28f.	Location (St City or Town	treet and Numb n, State)	er or Run	al Route Num	iber,
Ω	pital c		One Contiller 16 Contitu	vine Physicians To the box	ah of may be ovide		h				()			
	To the Hospital or Attending Physician: The lar within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certify Medica	ring Physician: To the bes al Examiner: On the basis and manners	of examination	n and/or ir	vestigation, in my	opinion, dea	id place, and ath occurred a	at the time, d	late and place,	anner as s	o the cause(s	i)
	To t To t	M	29b. Signature and tive of certif	ier •			29c. Licen	se number	15/	2	9d. Date signe	d (Month,	Day, Year)	
	0 00			i			D.S.	110c	4 g		7/16	10	+	
	Wax.		30. Name and address of perso	on who completed cause of	death (Item 23	3a) (Type,	Print) Adit	ya C	hopra		re 23	1		
	Sta Registr	_	31. Date filed (Month, Day, Yea		strar's Signatur	e A	mad s			, ,		<u></u>		

		1 - State Registrar Ce	partment of Health and Mer ertificate of Death	Reg. No.
Physic		1. Decedent's Name (First, Middle, Last) Stella Corvelli	$\mathcal{J}^{^{2}}$	Date of Death Month Day Year VLY 12 2007 1:00 A M
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
**************************************	K. A	Futurecare Chesapeake	Arnold If Under 1 Year If Under 24 Hrs. 8	Anne Arundel
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York
D	24	Usual Residence of Decedent		
farylar show	or	10a. State 10b. County 10c. City, Town or Miller:		10d. Inside City Limits 1 ☐ Yes 2X No
r 28a-i	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th with	a D	404 Honeywood Ct.	21108	USA
ISTYIANG Z1Z13-UU30 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28a-f show aumatic avent, the Medical Evantinat must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 25 No	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Z I Z I D-UU30 ed within 72 hours aft giene. er than "natural", or . I're Medical Exami	Completed	15 Decedent's Education 16a Dec	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
led w tygier therth	So	12 17. Father's Name (First, Middle, Last)	Homemaker	Own Home irst, Middle, Maiden Sumame)
E de la de	To Be	Pasquale Simeone	Philomena	
re, Marylis s 1 and 2 should f Health and Mer flem 27 la mark other traumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma		oute Number, City or Town, State, Zip Code)
5 0 E N 5			Honeywood Ct. Millers	
nor ages ant of h t: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)entombment Glen Have	ematory or other place)	
Baltimore, permit. Pages 1 an Department of Heal Important: if item 2 any injury or other		21. Signature of Funeral Service (Censee		esty Funeral Home, P.A.
Physiciar	1	23a. Part I. Enter the disease, or omplications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CDR ON ARY	nter the mode of dying, such as cardiac or re	Interval Between Onset and Death
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the eltending physicien and imposes 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to animodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
at the death certific by the ettending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ∇No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day Year	
w requires that been signed by should be deta	Ď.	Part II. Other significant continuous contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes
ysician: The law requires tysician: The law requires to certificate has been signed director, page 2 should be	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
VICION: The sicion: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (C	
ON O	ertification: To	1 Yes 2 No	of 28c. Injury at 28d	5 Residence 6 Other (Specify) I. Describe how injury occurred
DIVISIC To the Hospital or Attency within 24 hours after death To the Funeral Director:	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f	Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1		moneg no	D57531	July 12, 2007
(052)		30. Name and address of person who completed cause of death (Item 23a) (Typ Mohrt Neg 866/ Villerans Hu	e, Print) Suite 204	29d. Date signed (Month. Day, Year) July 12, 2007 Millersville my 21108
S Regis	tate strar	31. Date filed (Month, Day Near) 32. Registrat's Signature	Sperker	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** Crain 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury
If Under 1 Year | If Under 24 Hrs. Costal HOSPICE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, **Funeral** 1 2 M 2 □ F 79 218205507 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a 21801 28104 Riverside Drive USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be I ment of Health and Mental Pansy Emma Townsend Herman hawthorne Crain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a Debbie A. Crain/daughter 28104 Riverside Dr., Salisbury, MD 21801 permit. Pages 1 and Department of Health important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/21/07 Shad Point Cemetery Salisbury, MD 21. Signature of Funeral Service is nsee ²² Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DRSEASE **Physician** /Medical Due to (or as a consequence of) **Examiner** RDIOMYC PATH if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 ☐ Other (specify) Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 TYes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation (Month, Day Year) Natural 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 📶 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier /2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

COASTAL 32. Begistrar's Signature POBOX 173) SALISBURY WD 21807

31. Date filed (Month, Day, Year) JUN 2 0 200

			1 - For State Registrar	State of Marylan		artment of F rtificate of		•	giene Reg. No.	20117	24641
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month			3. Time of Death
	/Media	cal	Georg			Constant		July	12	2007	12:22 A M
À	Examin	er	4a. Facility Name (If not institution, give				or Location of Death			County of Death	1_
24.	Funeral Director		Frederick Memoris 5. Social Security Number 6. Security Number 086-18-6022 11 Usual Residence of Decedent		last birthday) Yrs.	Frede: If Under 1 Year Months Days		8. Date of Bir (Month, Da FEB . 23	th v. Year)	Frederic 9. Birthp Cour 126 Indi	lace (State or Foreign
	death with the Maryland ms 23a or 28a-f show r must be notifiled at	tor	10a. State 10b. County Maryland Freder		y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2X No
	th the or 283	Direc	10e. Street and Number			10f. Zip Code				izen of What Cour	•
	s 23a	ral	5955 Quinn Orchard		2 1	21704			Unit		
0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1944~		was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 🎇 No	Hispanic Origin? (Spr an, Mexican, Puerto Specify:	ecity Yes of No Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.
ה ה	"natu	letec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of work	ing	16b. Ki	nd of Business/Ind	dustry
7	withir ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		DO NOT use retire ctrical E	•		E1e	ctrical	Corporation
	e filed al Hyg other vent, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	l		
70	Menta	70	Gus	Constantine			Bessie			ızanis	
2	12 sho h and 7 is mi traum		19a. Informant's Name/Relationship (7			-	and Number or Run				,
บ	Healt Healt tem 27		Felecia Constanti 20a. Method of Disposition			29 PONG F psition (Name of matory or other pla	ountain C	Date New		cation - City or To	
Dallimor	Pages ment of ant: If It ury or o		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	nemoval nom state	ok Hil	L1 Cemete	ry 07/20			lerick, M	laryland
סמוו	permit. Depart Import any inj		21. Signature of Funeral Service Licen	Palenam			^{ess of Facility} Sta sumtown P				21702
	Physician	11	23a. Part1. Errer the disease, or comp shock of heart failure. List only of Immediate ause (Final disease or condition			20	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
-	/Medical Examiner		resulting in death)	a. Due to (or as a consequence	uence of):	niev					1 3009
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events	bDue to (or as a consequent	uence of):						
I	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):					-	· · · · ·
0100,	rificate be executed g physician and as the burial-transit	edical E		d							
O. DOX O	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 buring after death. Within 24 buring after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnanc □ Other (specify) _	у		1	23d. Date of delive Month	ery Day Year
Cords, r	quires that en signed b uld be deta	by P	Part II. Other significant conditions of	-	-	nderlying cause giv	ven in Part I.	23e. Did t			ne cause of death?
ב	The law re	Completed						24a. Was autor perfo 1□ Yes	osy ormed?	prior to con death?	psy findings available mpletion of cause of
2	iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		ot all DOA Oth	26. Place of Deatl				
5	Phys	To	1 ☐ Yes 2 No 27. Manner of Deat	28a. Date of Injury	ER/Outpatier 28b. Time o	IL 3 DOA	4 □ Nursing Ho	me 5 Resident		6 ☐Other (Specif	y)
5	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2 □ No				
	il or Atte after dea Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (3 City or Tox	Street an wn, State	d Number or Rura)	l Route Number,
	Hospita 24 hours Funeral etely filler	ledical C	(Check only 2 ☐ Medical Exam one)	/sician: To the best of my kno niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death occur	red at the time,	date and	d place, and due to	the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Dat	te signed (Month,	Day, Year)
•	.^			Hiron do	That		D5164	3	7/	12/02	
•	15/11/1		30. Name and address of person who	ompleted cause of death (Item 32. Jegistrar's Signa	23a) (Type,	Print)	Fred	en ola		mp 2	1212
	్ర Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	ture	rade	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

- 25			1- State of Maryland / Departing	cate of Death		gierre Reg. No.)	7 21.51.2
W. A. C.	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Dea Month	ath Day Yea	3. Firme-of Death
· ·	/Media		James Carpenter		July	15,200	7 9:15pm™
	Examir	er		City, Town, or Location of Deat arlotte Hal		4c. County of D	
	· · · · · · · · · · · · · · · · · · ·		Charles in a second	nder 1 Year If Under 24 Hrs			
	Funeral Director		428-12-9934 1MM 2□F 84 Yrs. Mon Usual Residence of Decedent		(Month, Da		Birthplace (State or Foreign Country) Mississip —
	yland low at		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-f sh	ctor	Md St. Mary's Charlotte	Hall			1 X Yes 2 No
	th the)ire		f. Zip Code		10g. Citizen of What	Country?
	23a ust b	Funeral Director	29449 Charlotte Hall Road	20622		USA	
	er deg	nne	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D ff Yes,	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fi	1 □ Never Married 2 □ Married 1 □ ▼Yes 2 □ No If ₹es, Give 1 □ Ye Year or Dates:	es 2 No Specify:		Specify:	Black
5-("natı	ete	(Specify only highest grade completed) (Give kind o.	Usual Occupation If work done during most of wo	rking	16b. Kind of Busine	ss/Industry
121	withir ene. than	d E	Elementary/Secondary (0-12) College (1-4or 5+)	Enforcement		Local	Covern
	filled Hygie ther ther	ပိ	12 Law 1		me (First, Middle,	Maiden Surname)	GOVEIII.
Maryland	d be ental ked o c eve	To Be	Unkown	Unkn	own	,	
J.	should ind Men marke umatic	F		Iress (Street and Number or R	ural Route Numbe	er, City or Town, State	e, Zip Code)
	alth a 27 is 27 is rtrai		Janice Carpenter/Daug N Law 430	3 Rye Dr.,	Waldorf	, Md 206	502
Baltimore,	of Her item		20a. Method of Disposition 20b. Place of Disposition	(Name of or other place)	Date	20c. Location - City	or Town, State
E	Pages nent of h int: If ite iry or of		4 Donation 5 Other (Specify) Cheltenham	cem. 7/2	3/07	Cheltenh	nam,Md
alti	permit. Departn Imports any Inju	ı	21. Signature of Funeral Service Licensee 22, Nam	ne and Address of Facility B	luford		
<u>m</u>	83 = 88			14TH St.,			20010
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardia	c or respiratory as	rrest,	Approximate Interval Between
- O	Physician		Immediate Cause (Final disease or condition a.	delatin			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a ns uence of):	_ ^			
В	- Z	_	Sequentially list conditions, b.	Y 644.			
	red rsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~			
	xecur al-trar	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):	0 1			
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68760,	tificate be executed g physician and as the burial-transit	edical	d.				
Box	leath cert attending for use a	-	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of	delivery
	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other	oic pregnancy r (specify)		Month	Day Year
P.0	that the de ned by the a detached t	hys	9 ☐ Unknown				
	ires tha signed be det	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.			e to the cause of death?
ord	w requir been si should I		Color Land.		101	/es 2 No 3 □	Probably 4 Unknown
Records,	has be	Completed	<u></u>		24a. Was	an 24b. Were	autopsy findings available to completion of cause of
	ysiclan: The is certificate hadirector, page	Corr			perfo 1∐ Yes	rmed? death	i? ′es 2∐ No
/ita	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		ath (Check only o	ne)	
or	Physiclan: r this certifica ral director, p	၉				dence 6 Other (S	pecify)
Division or Vital	ing After	Certification:	27. Magner of Death 1 Natural 5 □ Pending (Month, Day Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe f	now injury occurred	
isi	Attending r death. ector: After by the fune	icat	3 Suicide 6 Could not be 28e Place of injury. At home form street for		28f Location /9	Street and Number or	Rural Route Number,
Ο̈́	lor A after Dire	ertif	4 Homicide determined building, etc. (Specify)	olory, omoo	City or Tov	vn, State)	Harat House (Valliber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur of the death occur and manner stated and manner stated	rred at the time, date and placation, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and (as stated. due to the cause(s)
	thin 2 the comple	Medical	and manner stated. 29b. Signature and title a certifier	29c. License number		29d. Date signed (Mo	onth. Dav. Year)
N	F 3 F 8		XXX	D005157	I		A 0
	6		30. Name and 11 S of person who completed cause of death (Item 23a) (Type, Print)	0000 / 0 /	7	7/17/	0/
f-	(3)		3.1 3.5	ייי לוחו	0.600		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Hall, Md. 2	10622		
	Registr		JUL 18 2007 Result 1. Louis				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Пау **Physician** 6:40 PM July 9 2007 Lawrence Edward Campany /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 346 Chippewa Lane Lusby If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mississippi Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Month, Day, Year) 01/18/1932 **Funeral** Days Hours Min. †**∑**Μ 2□F 75 Director 426-40-5984 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show 1 ☐ Yes 2 🗖 No , or items 23a or 28a-f shaminer must be notified Director Charlottesville VA Albemarle 10g. Citizen of What Country? 10e. Street and Number death with 1550 Pantops Mountain Place Apt. 205 23911 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1949 1954 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ò white 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry residential College (1-4or 5+) Elementary/Secondary (0-12) contractor construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ara Nelson Campany Ann Marie Agner ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 346 Chippewa Lane, Lusby, MD 20657 Lawrence C. Campany, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Anatomy Gifts Registry 07-10-07 Hanover, MD gnature of Funeral Service Licensee 22 Name and Address of Facility any ir Rausch Funeral Home, PA PO Box 100 Owings MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNCER COLON **Physician** 142 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9□Unknown 9 Unknown þ Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 s 2 No certificate 1□ Yes 26. Place of Death (Check only one) Be Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Son's Home No No 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20078 death (Item 23a) (Type, Print) 30. Name and address of person who complete d caus 32. Registras Signature 31. Date filed (Month, Day, Year) State Blaturi 10 2007 JUL Registrar

			For State	State of Mary	-	rtment of H tificate of L			giene Reg. No.	007	24644
	_		Registrar 1. Decedent's Name (First, Middle, Las	t)		intouto of L		2. Date of Dea	ıth		3. Time of Death
	Physicia	_	Charles Dewey	Crawford,	Jr.			July 7	, 200	Year 7	8:43 P. M
	/Medic Examin	-	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			ounty of Deat	
			Calvert Memorial				Frederic			alvert	
	Funeral		5. Social Security Number 6. Se	FM 2DE	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)		hplace (State or Foreign untry)
	Director		231-62-6839 Usual Residence of Decedent	62	2			11–26–	1944	LA	
	/land low		10a. State 10b. County	10	c. City, Town or Loc	cation					10d. Inside City Limits
	a-f sh ified	ito	MD Calvert		Lusby						1 □ Yes 2 □ No
	or 28	Jire	10e. Street and Number			10f. Zip Code				n of What Co	
	ath w	Funeral Director	13008 Iroquois Wa		T. C.	20657	011-010-	-7		ed Sta	
	er de items	i.	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces?	r in U.S. 13. V	f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	Rican, etc.)	1"	Black, White	
20	ırs aft Xami	by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	I□Yes 21 No	Specify:		S	pecify: W	Mite
5	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show the the Medical Examiner must be notified at ent, the Medical Examiner.	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Deced	lent's Usual Occup	ation	ina	16b. Kind	of Business/	Industry
7	thin 7 ie. ian "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worki)	,,,,g			
7	ed wi ygien ner th nt, the			1	Proj	ect Evalı	lator 18. Mother's Name	/Eirst Middle		overnn	ent / VISTA
	be fil ad oth even	å	17. Father's Name (First, Middle, Last) Charles Dewey Cra	awford. Sr.			Reta Ma		Waldell St	irriarrie)	
Š	hould d Mer marke	၉	19a. Informant's Name/Relationship (7		19b. Mailin	a Address (Street	and Number or Run		er. City or 1	own, State, 2	Zip Code)
<u>Z</u>	nd 2 s Ith an 27 Is i		Jane D. Crawford	**.		•	s Way, L		-		
Ď,	s 1 ar f Hea ltem 3		20a. Method of Disposition		20b. Place of Dispo cemetery, cren			Date		tion - City or	
<u> </u>	Page nent o nt: If iry or		1 ☐ Burial 2 MCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State				2/2007	Alexa	andria	, Virginia
Dallimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentle Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen			. Name and Addres					ome, P.A.
۵_	9 3 E 2	19	JK 1.5	dt			600, Lus			d 2065	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the one cause on each line.	e death. Do not ent	er the mode of dyir	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		Tooling in Journ,	Due to (or as a co							1 hour
	外。	ē	Sequentially list conditions, if any, leading to immediate	b. Pneumoni Due to (or as a co							
	uted d ansit	min in	Sequentially list conditions, if any, leading to immediate cause. Lines on original Cause (Disease or injury that initiated events	C							
Ď.	an an	Exa	resulting in death) Last	Due to (or as a co	onsequence of):						
8/00,	death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner		d							
٥	ertific ling p	Mec	IF FEMALE:	23c. If yes, outcome pf p	orognanov		-		00		P
מס	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	1		23	d. Date of de Month	Day Year
5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown							
S,	that ned by deta		Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	e contribute t	o the cause of death?
g	requires that een signed b nould be deta	ed by						10	Yes 2X	No 3□P	robably 4 Unknown
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	sician: The law certificate has b irector, page 2 s	Completed							rmed? 2 🙀 No	death?	s 2□No
VItal	ctor, I	Be C	25. Was case referred to medical examiner?			Lou	26. Place of Deat	h (Check only o	ne)		
2	Physician: this certific ral director,	2	1 ☐ Yes 2√∑ No	Hospital: 1 Inpatient			4 🗆 Nursing no				ecify)
	fter	io ::	27. Manner of Death 1 Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	Wor	k? K? Yes 2 □ No	28d. Describe	now injury	occurred	
UIVISION	or Attending ter death. Irector: After In by the fune	icat	3 Suicide 6 Could not be	28e. Place of injury	- At home, farm, str			28f. Location (Street and	Number or F	lural Route Number,
≧	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Certification:	4 Homicide	building, etc. (Specify)			City or To	wn, State)		
	ospita hours unera ly fille		29a. Certifier 1 Certifying Ph	ysician: To the best of r	my knowledge, deat	h occurred at the ti	me, date and place,	, and due to the	cause(s) a	ind manner a	s stated.
	he Ho in 24 he Fu pletel	edical	one)	and manner stated							
	With Control	Ž	29b. Signature and title of certifier	R. m		29c. Licens					th, Day, Year)
}				Bennett		D251			July	9, 20	IU /
	15		30. Name and address of person who Charles W. Bennet		th (Item 23a) (Type, 45 H. G. 1		oad. Tuel	ov. Mari	Mand	20657	
5		ate	31. Date filed (Month, Day, Year)	32. Registr	Signature	L delicit I	Caa, Das	oy, nar	Zano	20031	
	Regist		JUL 1	0 2007 ▶ 32. Registr	due S.	GORNEL					
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		1- State of Maryland / De Registrar	partment of Health and I Certificate of Death		ene 200	7 2464
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physici /Medi		Elmira L. Cropper		June 16	Day Yeer	5:28 M
Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
		229 hazel Avenue	Salisbury		Wicomico)
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		8. Date of Birth (Month, Day, Y		hplace (State or Foreign
Director		217-44-1746 1 M 2 DXF 68 Yrs	i. Months Days Hours Will.	12/10/19		ryland
p a		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town of				
with the Maryland a or 28a-f show Le notified at	2					10d. Inside City Limits
889-f	octo	Maryland Wicomico Salis				1 □XYes 2 □ No
or 2	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
death v	Funeral	229 Hazel Avenue	21801		USA	
tems	nu nu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerlo	pecify Yes or No- D Rican, etc.)	14. Race - Amer Black, White	
or i	by F	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 X No Specify:		1	hite
72 hours after natural', or ite		3 Widowed 4 Divorced Year or Dates:				
of 2 should be filed within 72 hours aft the and Mental Hygiene. To a marked other than "natural", or traumatic event, the Madical Exami	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	king 16	b. Kind of Business/I	ndustry
within ene.	Ē	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	ļ.,	Nama at i a	
tygie ther ther	ပိ	17. Father's Name (First, Middle, Last)	usekeeper		Domestic	
12 should be filed within hard Montal Hygione. 7 is marked other than "raumatic event, Its Max	Be	Vaughn Charnick	Helen I	ne (First, Middle, Ma	iden Sumame)	
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2 sh and is rr			ailing Address (Street and Number or Ru			ip Code)
and lealth m 27			9 Hazel Ave., Salis			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show iny injury or other traumatic event, its Madical Examinal must be notified at Nace.		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 20b. Place of Discomptent, of	sposition (Name of crematory or other place)	Date 20	c. Location - City or 1	Town, State
Pag men ant: ury			ry Crematory 6/19	9/07	Salisbury	, MD
permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee	Holloway Funeral H 501 Snow Hill Rd.	lome Profe	ssional A	ssociation
20 E 9 9		THE WALL	501 Snow Hill Rd.,	Salisbur	y, MD 218	04
cate be executed xx bhysician and ithe burial-transit	dical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
the death certific by the attending p ached for use as	Physician/Medical	1 ☐ Yes 2 ☑ 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delik Month	very Day Year
Physician: The law requires that this certificate has been signed tr ral director. page 2 should be det	ρ	Part II. Other significant conditions contributing to death but not resulting in the Tobacco abuse	e underlying cause given in Part I.		co use contribute to	the cause of death? bably 4 □Unknown
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The law cate has i page 2 s	Ē		<u> </u>	autopsy	prior to co	opsy findings available ompletion of cause of
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ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		h Check only one		
Phys this al dii	2	1 Inpatient 2 ER/Outpa			e 6 □Other (Spec	ify)
ding I	0	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	y Work?	28d. Describe how	injury occurred	
tend leath tor:	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 200 Place of Injury At home form	M 1 □ Yes 2 □ No			
or At fter of Nirec n by	≣	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui State)	ral Route Number,
ital irs al						
To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de construction and/or and manner stated.	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the Within Comp	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
IDA		Das. M.D.	D57952	0	5/18/20	007
ya.		30. Name and address of person who completed cause of death (Item 23a) (Type Babulal Das, 106 Mil ford)		1. ^ d	MDOIG	5 A 11.
V		31. Date filed (Month, Day, Year) 32. Projectrar's Signature	1 7 JUFU BA	ISDUN	· (V 212	504
Sta Registr		JUN 2 0 2007	1 4	/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 12 Year **Physician** 05:53 AM 07 Ko bert 2007 reorge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 31, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□F 87 459-07-3405 1920 Director Texas Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Arnold Anne Arundel Director Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21012 710 Capri Road Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Completed by White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mae Savage Raymond C. Nipper ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4405 Eaton Place, Alexandria, VA 22310 19a. Informant's Name/Relationship (Type. Print) Bonnie B. Iredell/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 4, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Hwy Homes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myasthinia **Physician** 5 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): physician IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 Tyes page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

anchi2

egistrar's Signature

30. Namerand address of cerson-who completed cause of death (Item 23a) (Type, Print)

1 7 2007

29c. License number

modical Pkry Angolis

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ROBERT L. DAY, SR. July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Director 79 5/18/1928 217-24-4188 Usual Residence of Decedent 10c. City, Town or Location 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Harford Director Darlington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3307 Dublin Road 21034 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or ite 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **X**No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Manager 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic events 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Heaton Day, Jr. Anna May Forward ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean C. Day/Wife 3307 Dublin Road, Darlington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State Dublin So. Cemeterv 7/29/2007 Darlington, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Dod Harkins Funeral Home, Inc., Delta, PA and 1. Cit is the disease, or complications that caused the deat. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Hemorrhagic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ

23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Pont) pper Chesapeake Dr.

Dav

26

USA

2007

9. Birthplace (State or Foreign

10d. Inside City Limits

17314

Approximate Interval Between Onset and Death

1 ☐ Yes 🏖 No

Maryland

14. Race - American Indian,

Specify: White

Automotive

4c. County of Death

Harford

State Registrar

Completed

Be

Certification: To

Medical

25. Was case referred to medical

2 D

5 Pending investigation

6 Could not be determined

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

32 Registrar's Signature

examiner'

1 🗌 Yes

27. Mann of Death

2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

(Check only

Ving

29b. Signature and title of certifier

certificate has been

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice

Σ

Division or Vital

28b. Time of

			1 - For Amend #5 Registrar	per FH 07	Maryland/ -25-2007	CNM Ce	artment of F	lealth a	and Men		ene g. No. 2 0 1	7 21	648
2		10	1. Decedent's Name (First, Middl	e, Last)						Date of Death	1		e of Death
	Physici		David	G.			Fav.	Sr.		Month uly 17		9:5	0 P M
	/Medic Examir		4a. Facility Name (If not institution		ier)		4b. City, Town, o			<u>ur</u>	4c. County of I		() I
	LAGIIII	101	3942 Rosewood	Road			Monrovia				Freder	ick	
	Funeral		5.002-28142239		Age (In yrs. last bi	rthday)	If Under 1 Year	If Under	24 Hrs. 8. I	Date of Birth	a	Birthplace (Sta	te or Foreign
п	Director		022-28-2257	1 ∑ M 2□F	67	Yrs.	Months Days	Hours	Min. Ma	Month, Day, rch 5,	1940 M	^{Country)} lassachu	setts
400			Usual Residence of Decedent										
	nylar how	L	10a. State 10b. County		10c. City, Tow	vn or Lo	ocation						City Limits
	e Ma 3a-f s tiffied	양	Maryland Fred	erick		Mo	nrovia					1 1 Y	es 2⊠No
	er 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	t Country?	
	23a ust k		3942 Rosewood	Road			21	770			United	States	
	r de er m	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S. es?	13.	Was Decedent of H If Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Specify n, Puerto Rica	Yes or No- in, etc.)		American Indian White, etc.	1
36	afte or it		1 □ Never Married 2 🖾 Marri	If Yes. Give			1 ☐ Yes 2 ☒ No				Specify:	Whit	e
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	d by	3 Widowed 4 Divorced		s: 57–61								
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12	withir iene. than the M	E D	Elementary/Secondary (0-12)	College (1-4			rnalist	2)			N		
2	be filed within 72 hours after death with the Marylan tital Hygiene. do other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle,	/ ast)		Jou	rnalist	18 Mothe	ar'e Namo /Fir	et Middle M	Newspa	per	
and		Be		Last/					,		aideri Surname)		
Ž	should by	မ	Leo M. Fay 19a. Informant's Name/Relations	hin (Time (Print)	40		4 deluces (044		y M. K				
Maryland	2 8 S			-			ng Address (Street						
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign ture of Funeral Service	Licensee			2. Name and Addre		beau		uneral H	· ·	
				Jua -		_	E. Ridge						
8			23a. Part1. Enter the disease of shock, or heart failure. List	only one cause on eac	h line.	not ent	er the mode of dyin	ng, such as	cardiac or res	spiratory arres	st,	Approxir Interval	nate Between nd Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	UNG A	101	AS74 SE	2				Onlock an	id Doddii
	/Medical Examiner		resulting in death)	Due to (or	as a consequence								
		_	Sequentially list conditions,	b. Dueb to day	as a nonsequence		AL (CANC	er				
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387	phys the	dical		d									
9 X	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outco	me of pregnancy								
Box	eath atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 ☐ Fetal death It at time of death		Ectopic pregnancy Other (specify)	/			23d. Date of Month	delivery Day	Year
	he d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknow		ÞΓ	JOtner (specify)						
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or Vital Records,	sign sign d be	d by			Ů		, , ,				3 2 □ No 3 1		
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<u>a</u>										1□ Yes 2	No 1 1	Yes 2□No	
₹	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:			t 3DDOA Othe		of Death (Ch	eck only one,)		
ō	Phys this raldi	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inp	atient 2 ER/Ou	itpatien Time of	S DOA	4 ⊔ Nu			nce 6 □Other (5	Specify)	
no	ding F h. After funera	ion	1 Natural 5 ☐ Pendin	g (Month,	Day Year)	Injury	Worl	ya≀ k? Yes 2∐!		Describe nov	v injury occurred		
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Division	after after Dire	Certification:	4 ☐ Homicide determ	building	etc. (Specify)	,	,,,		201.	City or Town,	State)	i riulai riodie iv	arriber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1X Certifyin	ig Physician: To the be	est of my knowledge	e, death	occurred at the tin	ne, date an	id place, and	due to the car	use(s) and manne	r as stated	
	e Ho 24 h e Fu letely	edical	(Check only 2 Medical one)	Examiner: On the basi and many	s of examination ar	nd/or in	vestigation, in my o	pinion, dea	th occurred a	t the time, da	te and place, and	due to the caus	e(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. License	e number		290	d. Date signed (M	lonth, Day, Year	-)
) 8	11/1	>		DC MO	3310	9		July 18,	2007	
	10	1	30. Name and address of port in	who molete ause	of death (Item 23a)	(Type		_	1		oury 10,	2007	
	10		James Hyang,		Reservoi			Washi	ngton.	DC 20	007		
	Sta	te	31. Date filed (Month, Day, Year)	32 Ben	istrar's Signature				J - 3,				
	Registr	ar	JUL 1	2007	en &	A	now !						

	State Registrar 1. Decedent's Name (First, Middle, L	ast)		Ce	rtificate of L	Jeath	2. Date of De			3. Time of Death	
an al -	Llovd Jame	s Fry	7e				July	17, Day	200 ^{Year}	5:30 P	
	4a. Facility Name (If not institution, gi		nber)		4b. City, Town, or	Location of Death		4c.	County of Death		
y.	3855 Shadywo				Jeffer				rederi		
	223-22-7852	Sex M∑M 2□F	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug 1	ay, Year)	9. Birth Coul	place (State or Forei intry) DC	
	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation	<u>.</u>				10d. Inside City Limi	
응	MD Freder	ick	Je	ffers	on					1 □Yes 2 🙀 N	
Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	ntry?	
<u>ra</u>	3855 Shadywood	Drive	A-1	- 1	2175				s. of A		
by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 12 Yes If Yes, Giv Year or Da	rces? 2 No e		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 🌠 No		ecity Yes of No Rican, etc.))-	o. 14. Race - American Indian, Black, White, etc. Specify: White		
ed ed	15. Decedent's I	Education		16a. Dece	dent's Usual Occup	ation	da a	16b. Ki	ind of Business/In	dustry	
Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work done of DO NOT use retired	l)	arig				
္ပ	10			Sel	f Employ	4			onstruc	tion	
Be	17. Father's Name (First, Middle, Las	st)				18. Mother's Nam	, ,	,	Surname)		
유 _	Chester Frye					Lucille					
	19a. Informant's Name/Relationship Christine Luns	(Type. Print) Sford Fi	cve -	1	ng Address (Street a						
-	20a. Method of Disposition	/	206 1	Place of Disno	Shadywo	1	A-I,J		ocation - City or To		
	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	rify)	State I	cemetery, cre sovett sion C	matory.or.other.plac .sville !emeterv	July 20	y 20	Love	ettsvil	le, VA	
	21. Signatule of Funeral Service Lice	Mas In	II cc)4 9 1	2. Name and Addres	ctin Ci	rcle,S	E, Le	eral Ch eesburg	apels ,VA 201	
	23a. Part1. Enter the disease, or conshock, or heart failure. List onling the disease or condition resulting in death)	_a. Acur	aused the deat ach line. C UM or as a consec	er a	NO Lau	CE GA	STRIC (blee	ed	Approximate Interval Between Onset and Death	
Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	FAILU		to 7	Thrive	ection				wk	
edical	IF FEMALE:				vchue	YU/mo.	NARY	disc	ease	YRS	
Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	decedent pregnant e past 12 months? Yes 2 \subseteq No 23c. If yes, outcome pr pregnancy 1 \subseteq Live birth 2 \subseteq Fetal death 3 \subseteq Ectopic pregnancy 4 \subseteq Pregnant at time of death 5 \subseteq Other (specify)							23d. Date of deliv Month	ery Day Year	
	Part II. Other significant conditions Hyper Fents 10 M	contributing to de	i i	Impro		en in Part I. YNCOM	0	d tobacco use contribute to the cause of			
Completed by	SCATO PENIAS						24a. Was auto perfo 1∐ Yes		prior to co death?	opsy findings availab mpletion of cause o 2 ☑ No	
m	25. Was case referred to medical examiner?	Hospital:			ot 3 DOA Othe	26. Place of Deal					
ition: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Mont	<u> </u>	28b. Time of Injury	of 28c. Injur	4 Nursing Ho	28d. Describe		6 ☐Other (Speci ry occurred	fy)	
Certification:	3 Suicide 6 Could not 4 Homicide determine	20e. Flace	of injury - At h	ome, farm, st	reet, factory, office		28f. Location (City or To		nd Number or Run e)	al Route Number,	
edical			asis of examina		th occurred at the tir nvestigation, in my o						
Σ	29b. Signature and title officerifier	Ke	ll	y M	29c License	if 7 49		29d. Da	te signed (Month,	Day, Year)	
	30. Name and address of person wh Dr. Allen Reil	lv. M.I	0. 80	1 Tol	Print) 1 House	Ave	Freder	ick	MD 2	1701	
ite	31. Date filed (Month, Pay, 1/ear)	007 32 8	egistrar's Sign	ature					,		

07-05315

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Leonard F	1.	For State	ate of N	Maryland		rtment of tificate of		nd N	/lental	Hygie		. No.	Ü.	7 2465
Physician	1	egistrar . Decedent's Name (First, Midd	lle,Last)	-						M	ate of Death onth	Day Year		3. Time of Death 0110 hrs
Medical Examine		Richa		Leona		Faber	b, City, Town,	or Loc	ation of D		ly 11, 200	26. County of	Death	01101113
43	4	la. Facility Name (if not instituti Anne Arundel Medica		et and number	1)		Annapolis		adon of D	out.		Anne Aru		
Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. la	ast birthday)	If Under 1 Y		If Under 24	_	Date of Birth	(MM/DD/YYYY)	9. Birth Foreign	place (State or
Director	١	216-27-3217	1 X M	2F	24	Yrs		ays	Hours	Min.	09-05-	-1982		ntry) MD
	41	Usual Residence of Decedent			10c City	Town or Locat	ion					· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
ow any		,		3 ₀ 1	Dea						i la			1 Yes 2 X No
rryland ka-f sh	Director	MD Anne 10e. Street and Number	Arund	TET	Dea	. <u>re</u>	10f. Zip Cod	e			10	g. Citizen of Wha	at Coun	ry?
the Ma a or 28	5	618 Irvin Av	enue					207	'51			USA		
auth with the Maryland items 23a or 28a-f show ust be notified at once.	ᇹ	11. Marital Status	12.	Was Deceder			s Decedent of es, specify Cu	Hispar	nic Origin?			14. Race White		an Indian, Black,
r death	Funeral	1 X Never Married 2	vorced If Ye	Yes	2 X No	1	Yes 2 X					Specify:	7.7k	nite
ural",	<u>S</u>	3 Widowed 4 D 15. Decedent's Education (Sp	l or D	ates:	ompleted)	16a. Deceder	nt's Usual Occu	pation	(Give kind	d of work	done	16b. Kind of Bus		
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Me ma Re C ev	요 일	19a. Informant's Name/Relation			aber	1.1		treet a	nd Numbe	er or Rural		ber, City or Towl	ı, State,	Zip Code)
MD and 2 sho alth and m 27 is aumati		Richard D. Fa	ber,	father	1 00%	Place of Dispo	O. Box			eale,		20751	City or	Town, State
ore, es lan of Hea of Hea		20a. Method of Disposition 1 Burial 2 X Cremati	on 3 F	Removal from	State	crematory or o	ther place)						•	
Baltimore, pernit. Pages I ar Department of Hee Important: If ite	-	4 Donation 5 Other 21. Signature of Funeral Service	Specify:		Me	etropol:	itan Cr	ress of	tory Facility	7/13	3/07	Alexan neral H		
Bal permi Depar Impo	- 1	William R	6	un	_	8	325 Mt.	На	armon	y Lai	ne, Ow	ings, M	D 20	
Physician		23a. Part I. Enter the disease, failure. List only one caus	or complication	ons that cause	ed the death	n. Do not enter	the mode of dy	ing, su	ich as card	diac or res	piratory arre	est, shock, or hea	art	Approximate Interval Between Onset and
Medical caminer	1	Immediate Cause (Final disease	se a. Har	nging		- 0-			-					Death
*		or condition resulting in death)	b.	to (or as a cor	nsequence	or);								
	ig	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		to (or as a co	nsequence (of):								
-	Examiner	(Lisease or injury that initiated events resulting in death) Las	C.	to (or as a co	nsequence	of):								
			d										_	
0, e be execut rsician and burial - tra	edical	UNPENDED		MENDED		anonou				_		23d. Date of	deliver	/
Box 6876(e death certificate the attending physed	sician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		23c. If yes, out	1	2 F	etal death	3	Ectopic p	oregnancy		Month		Day Year
OX 6 auth cer attend	Sicia	1 Yes 2 No 9 U	nknown d	Pregnant Unknowr	t at time of d	leath 5 C	other (Specify)					1		()
	Phy	Part II. Other significant con				resulting in the	underlying ca	use giv	en in Part	il.				the cause of death?
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	d by						·			_				bably 4 Unknown
ords v requi s been should	ompleted	<u> </u>									24a. Was autop	osy		stopsy findings available completion of cause of
Recc The lay	mo									_	1 Yes	2 No 1	Y	es 2 No
tal F	Be C	25. Was case referred to med examiner?		oital:		4 EDIO 1-11-		10	Mb	Nursing H		Residence 6	Othe	
of Vi	ဥ	1 ✓ Yes 2 No 27. Manner of Death		28a Date of	Injury	ER/Outpatie		`	at Work?	28	d. Describe	how injury occur		
on o	tion:	1 Natural 5 P	ending	FOUND: Jul 10, 200	ay,Year)	FOUND: 2340 hrs	1	Υe	es 2 🗸 1	No Si	ıbject har	nged self		
Division tal or Attendii rs after death al Director: A	ifica		vestigation ould not be			home, farm, str	eet, factory, of	fice bu	ilding, etc.		or Town, S	State)		ural Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death Funeral Director: After this certif tely filled in by the funeral director,	Certification:	4 Homicide	etermined		Emergen						05 Blaine	Rd., Deale, M		ted
he Ho in 24 l the Fu	Medical	29a. Certifier 1 Certifying one) 2 Medical E	xaminer: Or	n the basis of	examination	edge, death occ and/or investio	urred at the tir ation, in my or	ne, date pinion,	e and place death occ	ce, and du urred at th	e to the caus ie time, date	se(s) and manne and place, and	due to t	ne cause(s)
To t with To t	Med	29b. Signature and title of cer	an	id manner stat	ted				number	· -				onth, Day, Year)
		(aux	e A	AD.	Ope 1	~		D.C.N	1.E.			July 11, 2	007	
1-		30. Name and address of per				em 23a)	Ctrast D	dties s	ro MD	21201				
				Medical E	xaminer strar's Signa		Street, Ba		, e, IVID	Z 1ZU I				
St Regist	ate trar	1111	3 20	07	MILLER	S. B	parks							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? ()

		4	For State Registrar		,	Cer	tificate of l	Death			Reg. No	b. 0 0 7	64001
			1. Decedent's Name (First, Middle, Last)					2	Date of De	ath Da	ıy Year	3. Time of Death
	hysicia /Medica		Carl Gosc	inski								•	9:40 _м a
	xamine		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location	of Death	oury	1 40	2007 c. County of Deat	3.40
			ATLANTIC GENERAL	HOSPITAL			BERLI					WORCEST	ER
	neral ector		5. Sociał Security Number 6. Se 212–30–2729	x 7. Age (1. 3 xM 2□F 7. Age (1. 7. Ag	in yrs. last b 2	irthday) Yrs.	Months Days	If Under Hours	Min.	Date of Bin (Month, Da 12/19/	ıy, Year,) Co	nplace (State or Foreign untry) known
g			Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Tox		antina						
aryla	E E	٦	,				ation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
e N	reijin	Director	Maryland Worcest 10e. Street and Number	er	Berli	.I1	101 7: 0: 1:				10- 0	hi	
with	2		9714 Healthway D	wirra			10f. Zip Code 21811					itizen of What Co SA	untr y ?
deeth with the Maryland	TIME I	era	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. V	/as Decedent of H		igin? (Speci	fy Yes or No		14. Race - Ame	ncan Indian
Dattimore, Maryland 21215-0050 permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene.	Examinar	by Funeral	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If	Yes, specify Cuba	Specify:	n, Puerto Ri	can, etc.)		Black, White	
72 ho	Ical	ted	15. Decedent's Edu (Specify only highest grad	ication	168	a. Deced	ent's Usual Occupa	ation	t of working		16b. F	(ind of Business/	Industry
thin 7	Wed	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			ind of work done of NOT use retired	i)	it or working				
M be will will will will will will will wil	4	ပ္ပြဲ ပ	11	_	S	ales	man					ales	
d be fit	o o o	Be	17. Father's Name (First, Middle, Last)							First, Middle,	, Maidei	n Sumame)	
Men dia	a tic	ို	unknown						known				
, Mar and 2 sh salth and	er treum		19a. Informant's Name/Relationship (T) John Fitzmartin/				g Address (Street a Barbara						
Dall More	y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify,	Removal from State	cemet	ery, crem	ition (Name of atory or other plac	·	Dat			ocation - City or	
nit. P	injur	-	21. Signature of Funeral Service Licens	iee _	Anatom	y Gi	fts Regi	stry	7/13	/07	Gl	en Burni	sociation
n ad.	eny ir		Dom Ho	lla	_	HC 50	1 Snow H	unera	II HOM	e Proi	iess	MD 21aC	sociation 4
			23a. P. 1. Enter the disease, or comp	tications that cause th	e death. Do	-							Approximate
Phys	igion	-	hock, or heart failure. List only o	A. C. A. C.								JA	Interval Between Onset and Death
	dical		disease or condition resulting in death)	a. Due to (or as a c	LMOZ		-						Where
Exar	niner				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,							
		Je.	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence	of):							
ostificate be executed	pnysicien and s the burial-transit	Examiner	that initiated events	c									
, §			resulting in death) Last	Due to (or as a c	onsequence	of):							
ficate be ex	he br	S	(d									
	OP rd	Medical	IF FEMALE:										
		Iclan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 [h 3 🗆	Ectopic pregnancy					23d. Date of deli	
e death	ne en	SICI	1 Yes 2 No	4□Pregnant at tin 9□Unknown	ne of death	5 🗆	Other (specify)					MOHUI	Day Year
The law requires that the	etech	Phys	-		4 hi	in the same	deal de la	or in Book I		aan Dida			the cause of death?
, g	p eq .	ু ত্র	Part II. Other significant conditions co	nthouting to death but r	not resulting	in the un	derrying cause give	en in Par i				_	,
w require	hould	sted								, ,	Yes 2	- 140 3 F	Solution Television
	628	Completed								24a. Was autor	osy	24b. Were au	topsy findings available completion of cause of
Ē	pag	ဂ် ပ								1 ☐ Yes	2/21N	death? 1 ☐ Yes	2□ No
VII.	ector	ge	25. Was case referred to medical examiner?	Hospitat:			104		of Death (Check only o	опе)		
2 f	al dir	0	1 195 20110	Inpatient	2 ERVO			4 140				6 □Other (Spec	cify)
ding .	uner i	6	27. Manner of Death 1 ☑Naturat 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 280.	Time of Injury	28c. Injury Work	/ant <br Yes 2. □		d. Describe I	now inju	iry occurred	
Attender death	the the	Cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home f	arm etre		165 2 🗆		f Location /	Street a	nd Number or Q	ral Route Number,
after a	i d	Certification:	4 ☐ Homicide determined	building, etc. ((Specify)	ann, sue	et, ractory, onice		20	City or To			rar Houle Humber,
spita	e e e e e e e e e e e e e e e e e e e		29a. Certifier 1 Certifying Phy	sician: To the best of r	my knowledo	ne. death	occurred at the tim	ne, date an	nd place, an	d due to the	cause(s	and manner as	stated
UNISION OF VITA Othe Hospital or Attending Physician; within 24 hours after death.	eru	edical	(Check only 2 Medical Exami	ner: Un the basis of ex and manner stated	camination a	nd/or inv	estigation, in my of	pinion, dea	ath occurred	at the time,	date an	d place, and due	to the cause(s)
of the vithin		Ž -	29b. Signature and title of certifier				29c. License	number			29d. Da	ate signed (Monti	n, Day, Year)
- ×1	N		XII Kale	1	(- >	7	100	27	10		5	111/00	•
1 /	y 1	-	M Name and address of person who c	ompleted cause of deat	th (Item 23a)	(Type, F	Print)	0)	01			11110/	
10			Nelidon Bossolule	in and li	209	Coa	tel Had	luins	Feen	rct I	Colo	al. De	19744
	Stat	e '	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		<u> </u>	-				1	- 1 7

Registrar DHMH 17 Rev 1/2001 JUL 1 8 2007

Goscinski, Carl

DOB: 12/19/34 DOD! 7/11/07 TOD! 09:40

7-05/02	Please Type or Print in Black Indelible link. Ensure All Col	pies Are Legible.			
ngie Michelle Gonce	State of Maryland / Department of Health and Mental	Hygiene	U 3, 6 **	7 01 0	?
1- For State	Certificate of Death	Reg. No.	- J - 1	£ + 0	1
Registrar	Nama /First Middle Last	2. Date of Death	3. Ti	me of Death	٦

		- For State Registrar	Certificate of	Death		Reg. N	o. L 🔾	
Physici	an/	Decedent's Name (First, Middle,Last)				2. Date of Death Month Day July 25, 2007	y Year	3. Time of Death 0805 hrs
cal Exami		Angie Michele Gonce		1h City Town or	Location of Death		4c. County of Dear	
		4a. Facility Name (if not institution, give street and number) 14 Enchanted Hill Road	["	Owings Mill		W. A.	Baltimore Co	
Funeral		5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	If Under 1 Yea		8. Date of Birth (M	M/DD/YYYY) 9. B Fore	rthplace (State or
Director		213-43-7993 1 M 2 XF	20 Yrs.	Months Day	Hours Min.	Jan. 20		ountry) Virginia
any	95 1 4		c. City, Town or Locati	ion				10d. Inside City Limits
ž .	ř	Maryland Cecil	Perryvil1	Le				1 XX Yes 2 N
Aaryla 28a-f I at o	Director	10e. Street and Number		10f. Zip Code			Citizen of What Co	
th the Maryland 23a or 28a-f sho notified at once		19 Bay Circle Drive		21903			ited Stat	
after death with the Maryland al", or items 23a or 28a-f she tner must be notilied at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	er in U.S. 13. Wa	s Decedent of His es, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
or deat	Fur	3 Widowed 4 Divorced If Yes, Give Year	No	Yes 2 X No	specify:		Specify: Whi	.te
rs.afte	by	15. Decedent's Education (Specify only highest grade complete			tion (Give kind of w	ork done 16	b. Kind of Business	
2 hou "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during m		. DO NOT use retir	ed)		
uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	ďμ	12	Ноп	nemaker	1.0	XIIX Ibr	Own Hon	1e
should be filed within 72 hours and Mental Hygiene. 7 is marked other than "natur natic eyent, the Medical Exam	ပြ	17. Father's Name (First, Middle, Last)				(First, Middle, Maid th Heath	len Surname)	
d be fi lental arked	o Be	John Gonce 19a. Informant's Name/Relationship (Type, Print)	10h Mailin	a Address (Street		Rural Route Number	City or Town Sta	te Zin Code)
ages I and 2 should be filed within 72 hours a not of Health and Mental Hygiene. It: If Item 27 is marked other than "natural other traumatic event, the Medical Examit	ř	John Gonce / Father				Perryvill		
and 2 sho lealth and tem 27 is traumat		20a. Method of Disposition	20b. Place of Dispos				c. Location - City	or Town, State
rmit. Pages 1 a		1 X Burial 2 Cremation 3 Removal from State	crematory or oth		ry Jul		411.	. Marriel and
		4 Donation & Other Specify 21. Sign fure Furier Specify		Name and Addres	1 30.	ouch Fune:		. Ma <u>ryland</u> 21901
permit. Departn Imports injury		16 Call	1.13	27 South	Main St	reet. Nor	th East.	
hysician		23a. Part I. Enter the disease, o complications that caused the failure. List only one cause on each line.	e death. Do not enter t	the mode of dying	, such as cardiac o	r respiratory arrest,	shock, or heart	Approximate Inter- Between Onset at
'Medical aminer		Immediate Cause (Final disease a. Quetiapine i						Death
a		or condition resulting in death) Due to (or as a consequ	Jence of):					
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	uence of):					
	min	cause. Enter Underlying Cause						
ed nsit	Examine	events resulting in death) Last Due to (or as a consequ	Jence of):					
rou, icate be executed physician and the burial - transit	cal	X UNPENDED AMENDED 77	00 0 15	n 071 0/	7/07			
bU, ite be hysicia e burit	Medical	#23a,P11,2/ IF FEMALE: 23c. If yes, outcome	,28a-f, perMF of pregnancy	E.g8/1.9 <u>/</u>	//0/_TT	1	23d. Date of deliv	ery
BOX 68 / 0U death certificate be the attending physical for use as the bu	an/l	23b. Was decedent pregnant in the past 12 months?		etal death 3	Ectopic pregna	ancy	Month	Day Year
eath certifications as as	Physician/	1 Yes 2 No 9 V Unknown	me of death 5 Of	ther (Specify)				
t the de	F	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause	given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
s that igned b	<u>a</u>	Narcotic use				1 Yes	2 ✔ No 3 P	robably 4 Unknow
w requires to seen signal should be considered.	Completed by					24a. Was an autopsy		autopsy findings availa
3 5	ш					performe	death	?
e law e has ge 2 sl	ပိ	25. Was case referred to medical		26.Plac	e of Death (Check			
r: The lar tificate ha or, page 2	-	examiner?	2 ER/Outpatien	nt 3 DOA	Other Nursin	ng Home 5 Re	sidence 6 🗸 Ot	her: Scene
rsician: The lar iis certificate ha director, page 2	o Be	Innationt	Z ER/Outpatien					
ng Physician: The lar ofter this certificate ha meral director, page 2	ြို	1 Ves 2 No Inpatient 27. Manner of Death 28a. Date of Injury	28b. Time of	, ,	ury at Work?	28d. Describe hov	v injury occurred	
tending Physician: The lar eath. or: After this certificate ha the funeral director, page 2	n: To	1 ✓ Yes 2 No 28a. Date of Injury 27. Manner of Death 1 Natural 5 Pending 1 1 ✓ Yes 2 No 28a. Date of Injury (Month, Day,Yea	28b. Time of	1	ury at Work? Yes 2 X No	unk		
or Attending Physician: The lar fler death. Director: After this certificate ha in by the funeral director, page 2	n: To	1 ✓ Yes 2 No Pending Investigation 3 Suicide 6 X Could not be	28b. Time of	58 am 1	Yes 2 XNo	unk 28f. Location (Stre	eet and Number or	Rural Route Number, 0
spital or Attending Physician: The lar ours after death. eral Director: After this certificate ha filled in by the funeral director, page 2	n: To	1 ✓ Yes 2 No Inpatient 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) apa:	28b. Time of 2007 Fnd 7:5 ry - At home, farm, stre	58 am 1	Yes 2 X No building, etc.	unk 28f. Location (Stre or Town, Stat 14 Enchant	eet and Number or e) eed Hill Rd	Rural Route Number, C . Owings Mill:
the Hospital or Attending Physician: The land 24 hours after death. The Inneral Director: After this certificate had beleely filled in by the funeral director, page 2	Certification: To	1 ✓ Yes 2 No Inpatient 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) apa: 29a. Certifier 1 Certifying Physician: To the best of my No.	28b. Time of 2007 Fnd 7:5 ry - At home, farm, stre	58 am 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Yes 2 X No building, etc.	unk 28f. Location (Stre or Town, Stat 14 Enchant	eet and Number or e) eed Hill Rd s) and manner as s	Rural Route Number, C
officer death. ctor: A y the fu	Certification: To	1 ✓ Yes 2 No Inpatient 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my know) 2 ✓ Medical Examiner: On the basis of examinand manner stated.	28b. Time of 2007 Fnd 7:5 ry - At home, farm, stre	58 am 1 action, office turned at the time, attion, in my opinion	Yes 2 XNo building, etc. date and place, and	unk 28f. Location (Strept of Town, State 14 Finchant did use to the cause(state the time, date and	eet and Number or e) ed <u>Hill Rd</u> s) and manner as s d place, and due to	Rural Route Number, C • Owings Mill: tated. the cause(s)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	n: To	1 ✓ Yes 2 No Inpatient 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) apa: 29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examiner:	28b. Time of 2007 Fnd 7:5 ry - At home, farm, stre	58 am 1 aeet, factory, office urred at the time, ation, in my opinic 29c. Licer	Yes 2 XNo building, etc. date and place, and on, death occurred	unk 28f. Location (Street or Town, State 14 Finchant and the to the cause(state the time, date and the time, date and the time)	eet and Number or e) ed Hill Rd s) and manner as s d place, and due to	Rural Route Number, C Owings Mills tated. the cause(s)
JIVISION OF VITAL RECORDS, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Certification: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my know) 2 ✓ Medical Examiner: On the basis of examinand manner stated.	28b. Time of 2007 Fnd 7:5 ry - At home, farm, stre rument knowledge, death occu ination and/or investiga	58 am 1 aeet, factory, office urred at the time, ation, in my opinic 29c. Licer	Yes 2 XNo building, etc. date and place, and	unk 28f. Location (Street or Town, State 14 Finchant and the to the cause(state the time, date and the time, date and the time)	eet and Number or e) ed <u>Hill Rd</u> s) and manner as s d place, and due to	Rural Route Number, C Owings Mills tated. the cause(s)
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	Certification: To	1 ✓ Yes 2 No Inpatient 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my know) 2 ✓ Medical Examiner: On the basis of examinand manner stated.	28b. Time of 2007 Fnd 7:5 ry - At home, farm, streer thent knowledge, death occurnation and/or investigation and (Item 23a)	58 am 1 aet, factory, office urred at the time, ation, in my opinic 29c. Licer	Yes 2 XNo building, etc. date and place, and on, death occurred	unk 28f. Location (Stre or Town, Stat 14 Enchant due to the cause(sat the time, date and 2	eet and Number or e) ed Hill Rd s) and manner as s d place, and due to	Rural Route Number, C Owings Mills tated. the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2007 3:40 July P. M Cornelia Jane Goodwin 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9112 Bridgewater Street College Park Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 1 F Director 067-20-8263 80 Jun 11, Aubum, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified tx☐Yes 2☐No Directo Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rat", or Items 23a or Examiner must be r 9112 Bridgewater Street 20740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. and 2 should be filed within 72 hours after of ealth and Mental Hygiene.

m 27 is marked other than "natural", or iten her traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White If Yes, Give Year or Dates: Specify. þ Specify 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University of Maryland College (1-4or 5+) Elementary/Secondary (0-12) Associate Administrator College Park 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph W. Ferrell Charlotte King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 Lawrenceville Ave., Jefferson, GA Mark Goodwin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State ₽ = P 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Metropolitan Crematory July 18,2007 Alexandria, Virginia 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. MOLYGI Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the dise lie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosch **Physician** (erdus des cu disease or condition resulting in death) evotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1- Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 8 2007

304 32. Registrar's Signatu

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, p Certification: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title completed cause of death (Item 23a) (Type, Print) 32. Registrar's State Registrar **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Department of Health a 1- Registrar Certificate of Death		-	No.	01 (5:
	Physici		Decedent's Name (First, Middle, Last) Donald Earl Hill		Date of Death Month Ly 16	Day 2007	3. Time of Death 5:05 A M
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Summerville at Westminster 4b. City, Town, or Location of Westminster	of Death		4c. County of Death Carroll	
3	Funeral Director		5. Social Security Number 220-12-8377	Min. Api	Date of Birth Month, Day, Ye	9. Birth Cou. 1915 West	olace (State or Foreign htty) Virginia
	Maryland f show led at	or	Usual Residence of Decedent 10a. State				3. Time of Death 4. To Solve the arroll 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1
	th with the f 23a or 28a- ist be notif	al Direct	10e. Street and Number 4420 Black Rock Road 10f. Zip Code 21074				*
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexicar If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Ori		Yes or No- n, etc.)	Black, White,	etc.
Maryland 21215-0036	l within 72 ho Jene. r than "natul the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during mos life. DO NOT use retired) Office Clerk	st of working	De	b. Kind of Business/In epartment Health	dustry
land 2	ld be filed ental Hyg ked other ic event, i	To Be C	William C. Hill Albe	er's Name <i>(Fir</i> erta G.		iden Surname)	
	and 2 shou ealth and M n 27 is mar		19a. Informant's Name/Relationship (Type. Print) Deborah M. Harrison – daughter 19b. Mailing Address (Street and Number 918 Club Lane Street)				*
Baltimore,	Pages 1 a nent of Hea ant: If item ury or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 XRemoval from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Rosedale Cemetery Co.	July 19 200	Ma	rtinsburg,	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee M01072 934 South Main	street	Funer Hamps	al Home tead, Md.	21074
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		spiratory arrest	o	Interval Between
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
P.O. Box 6	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1				•
	quires that n signed t ıld be dett	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	1.			
Vital Records,		Completed			24a. Was an autopsy performe 1∐ Yes 2£0	prior to co	impletion of cause of
0	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	To Be	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu 27. Manner of Death 1 Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 Injury M 1 Yes 2 Injury M 1 Yes 2 Injury Nu 28c. Inju		5 ☐ Residence	e 6 Other (Speci	living
Division	ial or Atte s after des al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	he Hospital or in 24 hours afte he Funeral Dir pletely filled in	Medical (29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date an and manner stated.				
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number D 2544	13	-	. Date signed (Month,	017
	64		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tolm W. Muddletm 688 Poole Rd	e. Iv	intin	moter	m 12 2/157
	Sta Registi		31. Date filed (Month, Day, Year) 32. Regigirar's Signature				

State of Maryland / Department of	Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 14, 2007 **Physician** June S. Hession 3:05 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facilify Name (If not institution, give street and number) Examiner 9303 Ivanhoe Road Ft. Washington Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year June 9, 1924 9. Birthplace (State or Foreign Country) Minnesota 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Days Min. 242-22-9423 1 □ M 2¥XF Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. In the Maryland show int: If Item 27 Is marked other than "hatural", or Items 23a or 28a-f show nit: If Item 27 Is marked other than "hatural", or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County Maryland Prince George's Ft. Washington 1 ☐ Yes 2 XXVo Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9303 Ivanhoe Road 20744 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Mamed Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽ No Specify: White Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lyle M. Sweet Nichols ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8410 Willow Wood Drive Ft. Washington, Maryland Timothy V. Hession / Son permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemetery 08/06/2007 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signatur Funerai Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Phr11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2004 101del /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 244 No Month Day Year 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home **SIX** Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Watural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospital within 24 hours a 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of certific July 17, 2007 npleted cause of page ath (Item 23a) (Type, Print) 30. Name and address of person who co Ruy I-Kotzen 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 1,8 2007 State Registrar

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of I			Reg. No.	7 24657
	Dhusisi		1. Decedent's Name (First, Middle, L.	ast)				2. Date of De Month	ath Day Ye	3. Time of Death
	Physici /Medio		Marceline Star	nley Hami	mond			July	11, 200	7 12:45 p^{M}
	Examir		4a. Fecility Name (If not institution, gi	ve street and number	-)	4b. City, Town,	or Location of D	eath	4c. County of [Death
			Solomons Nurs	ing Cente	er			Island		lvert
	Funeral			Sex 7. A 1 □ M 2 🛱 F	ge (In yrs. last birthday	Months Days		Vin. (Month, Da	ıy, Year)	Birthplace (State or Foreign Country)
	Director		264-32-0583	ILIM ZME	78 Yrs.			8/23/	1928	FL
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	ehow	5								112 Yes 2 □ No
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	ours after death with the Maryla rei', or iteme 23a or 28e-f ehov Exercitiner ir vet be incitited at	ä	10e. Street and Number			10f. Zip Code				
	• 23g	Funerai	13320 Olivet F		A Francis II C 12		20657	2 (Speedy Ves or No	USA 14 Bace -	American Indian,
	er de	nu	11. Marital Status	12. Was Deceden		If Yes, specify Cub	oan, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Black, V	Vhite, etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates	1	1 ☐ Yes 2 💢 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-1 ehow fra Mailgal Exerciting transi be inclified at	edi	15. Decedent's E		16a Dec	edent's Usual Occu	pation		16b. Kind of Busin	ess/Industry
15	d within 72 ho pene. r then "natur ine Modicel	Completed	(Specify only highest g	rade completed)	(Giv	e kind of work done DO NOT use retire	during most of	working		
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an	ould be i Mental I arked of	To B	Howard Codding	r Stanle	v		Anni	e Ellen	Roberts	on
Maryland	s 1 and 2 should be filed f Heelth and Mental Hygi Item 27 is marked other other traumatic event, I	-	19a. Informant's Name/Relationship			ing Address (Stree	t and Number o	or Rural Route Numb	er, City or Town, Sta	te, Zip Code)
Ĕ	12 = d		Carl Hammond,	Tr /Son	133	2 Olive	t Road	, Lusby,	MD 2065	57
ē,	s 1 and 2 of Heelth item 27 other tra		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla		Date	20c. Location - Cit	
J0			1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		8	ake Cre		/12/2007	Beltsvi	lle, MD
altimore,	교원단금 .		21. Signature of Funeral Service Lice			22. Name and Addr			-Wood F.	
B	Depermine Depermine on y is		V. C. Wor	d				-	4D 20754	11., 1.11.
	. S.		23a. Part1. Enter the disease, or cor		ed the death. Do not e					Approximate
			shock, or heart failure. List onfi Immediate Cause (Final	y one cause on each		and the second		0.5	13.000	Interval Between Onset and Death
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	insit	Examiner	cause. Enter Underlying Cause (Disease or injury							
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3760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and tall director, page 2 should be detached for use as the burial-transit	icai E		d						
687	ficate physis the			u						
Box	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date o	delivery
ă	atter i for i	ciai	in the past 12 months?			□Ectopic pregnand □ Other (specify) _	cy		Month	Day Year
P.O.	that the de led by the a detached t	ıysi	9 Unknown	9□ Unknown						
	es that igned b	y PI	Part II. Other significant conditions	contributing to death	but not resulting in the	undertying cause gi	iven in Part I.	23e. Did	obacco use contribu	te to the cause of death?
ds	uires sign	d by	Diabetes 1	nellitus				1	Yes 2 □ No 3	Probably 4 Unknown
Records,	w requ been should	Completed	Athenoscien	alia Ca	som en i lar	ulan di	1 40 64	24a. Was	an 24b. Wer	e autopsy findings available
Re	has ge 2	d L		•			reuse	auto perfe	psy prio dea:	r to completion of cause of th?
a	ilcian: Th certificate rector, pag		Coronary	Hotery	direase	-		1 Tes		Yes 2□No
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of	Phys this ral di	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 🗆 Inpai	tient 2 ER/Outpatii				dence 6 Other (how injury occurred	<i>Эреспу)</i>
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Division	or A after Direction by	Certification:	4 Homicide determine	building,	etc. (Specify)	troot, ractory, orroo	,	City or To		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Certifying P	hysician: To the bes	st of my knowledge, dea	ith occurred at the t	time, date and c	place, and due to the	cause(s) and manne	er as stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year DUSAN 0155 M TARRISON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mandrin Chesapeake Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year **Funeral** 1□M 2XF Months Director 579-22-4038 06-09-1925 Wash., D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No **Funeral Director** Lothian Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 Bayard Road 20711 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by Specify: white 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margelos Sarah Virginia Grimm ပ George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 238 Bayard Road, Lothian, MD 20711 Susan L. Fennell, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-21-2007 Lothian, MD Mt. Zion Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Deirs Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 DEctopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2/2/No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 📂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Chief Medical Officer 29d. Date signed (Month, Day, Year) the Chesapeake D 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Michael J. LaPenta, M.D., 445 Defense Highway, Annapolis, MD 21401

32. Registrans Signature

2007▶

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 19 Michael Anthony Hutzol 2007 Ju₁y /Medical 12:05 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 45317 E. Othello Way California St. Mary's If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□F Yrs Director 030-44-3368 53 04/03/1954 Massachusetts Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at 1 ☐ Yes 2X No Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 45317 E. Othello Way 20619 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No δ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) <u> Aircraft Mechanic</u> U.S. Government 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Anthony Paul Hutzol Bertha Marie Levesque 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Debra K. Sisler/Friend 45317 E. Othello Way, California, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/09/2007 Arlington, Virginia Arlington National 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service License Kyle S. M01206 Simons 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alcohol **Physician** /Medical Due to (or as a consequence of): Examiner Lives 5 1 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami Chronic physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical led by the attending prodetached for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Anemia 1 ☐ Yes 2XNo 3 Probably 4 Unknown Completed Hylo Kalemin 24a. Was an autopsy performed?
1□ Yes 2 ▼ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Hy P. mumenemia certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2| No 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA hours after death.

Ineral Director: After this
y filled in by the funeral di 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 € Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22650 Cedar Lane Court, Leonardtown, Maryland Sureshbhai Patel, M.D.

and manner stated.

31. Date filed (Month Day, Year)

29c. License number

70062213

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** M ABYTO Maurice Johnson 12 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastel Hospice At the Lake 5. Social Security Number 6. Sex 7. Age Salisbu WICOMICO Salisburg
If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1**⊠′**M 2□ F 1948 Washington 58 403-06-6492 9-29-Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Salisbury Director Wicomico MARULAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Buckingham 713 21804 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRIS JOHNSON NAOmi ORRIS မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury Sister-in-law Buckingham Cir 9: UENS 713 md DEIRDRIE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Crematory Salisbury Salisbuey, Md 7-18-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility SEWART 821 WEST Salis. Mola 1801 Home FUNERA! Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Immediate Cause (Final disease or condition resulting in death) **Physician** patoma /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and defected for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 ☐Unknown has been si je 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes No page this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔫 🗘 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of funeral 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After pompletely filled in by the funeral 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Ivem 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

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		1 - State Registrar		-	rtificate of De	alth and Meath		ng. No.	4.400
Physicia /Medic		Decedent's Name (First, Middle, La Carrie		nes			2. Date of Deat Month 7	Day Year 16 2007	3. Time of Death 3:50 P
Examin		4a. Facility Name (If not institution, given 9360 Green Branch			4b. City, Town, or Loc Willards			4c. County of Deat	n
Funeral Director		5. Social Security Number 6. S 217-09-2028 Usual Residence of Decedent	Sex 7. Ag 1 □ M 2 💢 F	ge (In yrs. last birthday) 98 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10-31-1	Year) Co	nplace (State or Fore untry) v1and
-f show	tor	10a. State 10b. County MD Wicomi	60	10c. City, Town or Lo					10d. Inside City Lim
3a or 28a at be neti	al Director	10e. Street and Number 5266 Powelville R		TILLSVIII	10f. Zip Code 21850			0g. Citizen of What Co	untry?
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow eny injury or other treumatic event, the Modical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2X If Yes, Give Year or Dates:	No	Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes 2 No S	nic Origin? (Spelexican, Puerto pecify:	ecify Yes or No-	14. Race - Ame Black, White Specify: Wh:	e, etc.
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Mental Hygiene. arked other than atic event, the M	Be	12 17. Father's Name (First, Middle, Last Charlie	Whit		-			Agricultum Maiden Sumame)	ral
Ith and Me 27 is mark r treumstir	To	19a. Informant's Name/Relationship (Carole Jones Roge	Type, Print)	19b. Maili	ng Address (Street and Merwin Roa		Il Route Number,		ip Code)
ent of Heal nt: If item 2 ry or other		20a. Method of Disposition 1	Removal from State	20b. Place of Dispo cemetery, cre-			Date 2	20c. Location - City or Powellville	
Department of the important: If its end injury or of page.		21. Signature of Fineral Service Lice		2:	2. Name and Address of U.5 E. Main	Facility Bou	ınds Fune	eral Home	
ysician /ledical aminer	16	23a. Part. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	a consequence of:	er the mode of dying, st	ach as cardiac c	respiratory arre	991,	Approximate Interval Betweer Onset and Deatl
hysicia the bur	edical Examiner	cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	c.	a consequence of):					
ed by the attending p detached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1☐Live birth 4☐Pregnant a 9☐Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
been signed be should be det	þ	Part II. Other significant conditions of	contributing to death t	out not resulting in the u	nderlying cause given in	Part I.		eacco use contribute to	the cause of death
0 6	Completed						24a. Was ar autopsy perform 1 \(\text{Yes} \) 2	y prior to d	topsy findings avail ompletion of cause 2 [] No
ate has	S							16	
is certificate has drector, page 2	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		nt 3 DOA Other:	t ☐ Nursing Ho		nce 6 Other (Spec	1.4.
death. stor: After this certificate has r the funeral director, page 2	To Be	examiner?	28a. Date of Inju (Month, Da	ary 28b. Time o	ont 3 DOA Other: 2 f 28c. Injury at Work? M 1 Yes	1 Nursing Ho	me 5 Reside 28d. Describe ho	nce 6 Sother (Spec w injury occurred	Livir
death. stor: After this certificate has r the funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Pl	28a. Date of Inju (Month, Date) 28a. Place of Inju 28a. Place of Inju building, e	ury - At home, farm, str. (Specify) of my knowledge, deat of examination and/or in	ont 3 DOA Other: 2 f 28c. Injury at Work? M 1 Yes	Nursing Ho	me 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	nce 6 Other (Spec w injury occurred reet and Number or Ru , State)	ral Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 15 Day 2007 ear **Physician** JULY 1:55 P TEAMETTE THERESA JENKINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 2,1952 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💢 F 219-58-9781 54 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c, City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at 1 □Yes 2 No Funeral Director Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6720 Friendly Oak Place 20646 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Cleaning Food Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Short, Sr. Verdella ပ Μ. Kev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6720 Friendly Oak Place, LaPlata, Md. 20646 Bennie M. Jenkins Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State July 20, 2007 Gardens 4 ☐Donation 5 ☐ Other (Specify) Waldorf, Maryland Trinity Memorial 22. Name and Address of Facility
Williams Funeral Home, P.A 21. Signature of Funeral Service Licenses M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 ease, or complications that ca llure. List only one case on ea ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis

Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a ☐Yes 2☐No 9☐Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be de-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ atory 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Zerre Phende (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760. Hospital or Attending Physiclan; the

> B3 State Registrar

Medical

(Check only

temen 31. Date filed (Month, Day,

29b. Signature and title of certifier

shah

Year)

29c. License number

29d. Date signed (Month, Day, Year)

Johnson Br. Frederica MD 21702

and manner stated.

MIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07-05726 Aaron Kline Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Agron Joe Kline Agron Joe Ag	Physician/ Examiner Aaron Joel Kline 4a. Facility Name (if not institution, give street and number) Western Maryland Health System Braddock Campus Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day July 26, 2007 4c. County of Death Cumberland 4c. County of Death Allegany 4d. County of Death Cumberland 4d. County of Death Cumberland 4d. County of Death Allegany Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min:	
Annual College of Management (College of Control College of Control College of Control College of C	Aaron Joel Kline 4a. Facility Name (if not institution, give street and number) Western Maryland Health System Braddock Campus 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 14b. City, Town, or Location of Death Cumberland 4c. County of Death Allegany 4c. County of Death Allegany 4d. Foreign	
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1	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
1	Armed Forces? If Yes, specify Cuban, Mexican, Fuerto Rican, etc.)	
1	Tes 2 X No specify: Yes Specify: Whi	te
1	To Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/ir	idustry
1	during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+)	=
1	Carpenter Construc	tion
1	18.Mother's Name (First, Middle, Last)	
1	Darlene Avers	
1	Paul S. Kline Sr. 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State,	Zip Code)
1	P1 C VI in Co. (fother) UC-65 Box (690 Rompey, WV 26757	
1	Paul S. Kline Sr. (father) HC-65 Box 4690 Romney, WV 26757	Town, State
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Sequentially list conditions, if any, leading to immediate course and the property of the part of the	Komanor Illilliediate Oddoc (1 mar diodace at	
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30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 31. Date filed (Month, Day, Year) AUG 0 1 2007	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
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30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 31. Date filed (Month, Day, Year) AUG 0 1 2007		. WV
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 31. Date filed (Month, Day, Year) AUG 0 1 2007	Segification of Lowin, State) HC 65 Box 4690 Romney	
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Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar AUG 0 1 2007 Aug. Year) AUG 0 1 2007	≥ 29b. Signature and title of certifier	
State Registrar AUG 0 1 2007 32 Registrar's Signature	July 27, 2007 O.C.M.E. July 27, 2007	
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Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If them 27 is marked other then "neturer; or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at	To Be Completed by Funeral Director	Elementary/Seco	nda
Hyg Hyg	C	17. Father's Name	(Firs
Baltimore, Maryland 212 permit. Peges 1 and 2 should be filed with Department of Heelth and Mental Highten mportant: If Item 27 is marked other then by injury or other traumatic event, thank	O O	John Ber	na
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death. To the Funeral Director: Affer this certificate has been signed by the attendion or ours efter death. neral Director: After this certificete has been signed by the attending p filled in by the funeral director, page 2 should be detached for use as by Physician/Me Be Completed

of Vital Records, P.O.

Division

Certification: To 27. Manner of Death 29a. Certifier Medical

completely

institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Fruitland
Under 1 Year | If Under 24 Hrs. Main Street Wicomico 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠**M 2□F Months Days Hours 3 12/7/1919 New Jersey cedent b. County 10c. City, Town or Location Wicomico Fruitland 10f. Zip Code 10g. Citizen of What Country? Main Street 21826 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Amed Folces: 1XX)Yes 2 ☐ No If Yes, Give Year or Dates: Army 2 Marned 1 ☐ Yes 2 🛣 No Specify: Specify: White Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education only highest grade completed) 16b. Kind of Business/Industry ry (0-12) College (1-4or 5+) Truck Driver Conwimer t, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rd Kunie, Sr. Mary Seaster (Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerity/daughter 420 E. Main St., Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State remation 3 Removal from State Other (Specify) Salisbury Crematory 6/19/07 Salisbury, MD I Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21826 CFSP isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ilure. List only one cause on each line. Cardiovascular disease Afren psclovotie Due to (or as a consequence of) ons, diate Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIVI 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₹0 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and stane, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

5 Pending investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

29c. License number 132014

504 13

3 DOA

9/-

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Salisky MAD 21809.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

3. Time of Death

10:10

10d. Inside City Limits 1 ¥ Yes 2 ☐ No

Approximate Interval Between Onset and Death

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHLIM MOONDIA 106 millord

31. Date filed (Month, Day, Year)

1 Yes 2 No

1 Natural

2 Accident

4 | Homicide

3 ☐ Suicide

JUN 2 0 2007



DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Tatiana Lutchenkov 7/15/2007 8:10aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 486 Lisa Ave. Odenton Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/23/1931 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2√2 F Days Hours Min. 76 553-44-2851 Yugoślavia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MDAnne Arundel 1 ☐ Yes 2 ☐ No Gambrills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2543 Symphony Lane 21054 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes XX No Specify Specify. 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Linguist NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Konstantin Trankovsky Zinaida Nikolin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alex Hrapunov Son 13342 Blackwells Mill Rd. Goldvein, VA 22720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XPurial 2 □ Cremation 3 □ Removal from State Epiphany Cemetery 7/18/2007 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

Department of Health a Important: If item 27 Is any injury or other trainonce.

Funeral

Director

r 28a-f sh notified

ral", or items 23a or Examiner must be r

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or in or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

Examiner

physician and s the burial-trans attending ph for use as the signed by the a d be detached for

Physician/Medical Completed by Be Medical Certification: To

The law requires that the death certificate be execu page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p



IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1
Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) FRIEND'S 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2007

23d. Date of delivery

2 No

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

HOME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610, Glen Burnie CRAIN 1600 31. Date filed (Month, Day,

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

Date filed /Month

JUL 20

gistrar's Signature

ID

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

Year)

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32. Registras Signature

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			For State Registrar	State of Ma	aryland /		rtment of H tificate of I		nd Me		giene Reg. No. 🖊 🕻	1.1.	21.668			
4	Physici: /Medic		1. Decedent's Name (First, Middle, L Leonard	More heo	d				2.	Date of Dea Month 7/15	/2007	Year	3. Time of Death 3:05ant			
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	pun		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation					1	0d. Inside City Limits			
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1☆ Yes 2 N If Yes, Give Year or Dates:)	/as Decedent of H Yes, specify Cuba ☐ Yes 21 No	ispanic Origin In, Mexican, F Specify:	n? (Specif Puerto Rid	y Yes or No- can, etc.)	14. Ra Bi	ace - Americ ack, White, aify: Wh				
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Baltimore,	Pages 1 nent of H ant: If ite ury or otl		20a. Method of Disposition 12 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Content of the Conte		1	nce	ition (Name of atory or other plac Cemetery	-		/2007	20c. Location	etown,	VA			
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	Total.		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl	mplications that caused y one cause on each lin	the death. D	o not ente	r the mode of dyin	g, such as ca	ırdiac or r	espiratory a	rest,		Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cong	estive	e h	east +	milu	ــــــ				Oriset and Beath			
	Examiner			Due to (or see	a consequenc	e of):	east of	de	-19	2						
	TD .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequen	of):	y	,								
	ecuter and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	OPU											
68760,	cate be executed physician and the burial-transit			Due to (or as a	a consequenc	.6 01).										
		ledical		d												
.O. Box	w requires that the death certifi been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal dea		Ectopic pregnancy Other <i>(specify)</i>	'				ate of delive Month	ery Day Year			
0	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions			j in the un	derlying cause give	en in Part I.		23e. Did to	obacco use co	ntribute to th	ne cause of death?			
ord	equire sen sig ould b		diabetes	mellitu	5 /			···	_	1 🗆 '	Yes 2□ No	3 ☐ Prob	pably 4 Unknown			
I Records,	The la ate has page 2	omplet	omplet	omplet	Completed			· · · · · · · · · · · · · · · · · · ·		· · · · <u> </u>		_	24a. Was autor perfo 1∐ Yes		prior to cor death?	psy findings available mpletion of cause of 2 No
or Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		f Death (Check only o	ne)					
	Phys this ral dii	<u>고</u>	1 ☐ Yes 25000 27. Manner of Death	1 ☐ Inpatie	nt 2 ☐ ER/0	Outpatient o. Time of	3 DUA	4 ∐ Nursi	<u> </u>		dence 6 🗆 C		y)			
on	Attending r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Injur Worl M 1 🗆	k? Yes 2 ∐ No			,.,.,					
Division	al or Atte s after des l Directo	Certification:	3 ☐ Suicide 6 ☐ Could not determined		iry - At home, c. (Specify)	farm, stre	et, factory, office		281	Location (S City or Tov	on (Street and Number or Rural Route Number, Town, State)					
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		Physiclan: To the best of aminer: On the basis of and manner sta	examination											
	To the comp	M	29b. Signature and title of certifier	2	1		29c. Licens	e number			29d. Date sign	ned (Month,	Day, Year)			
	(8)		· Kestu	book	12,	MD	D.	4021	0		7-11	0-0	*			
	(M)		30. Name and address of person who so the filed (Month, Day, Year)	completed cause of de	eath (Item 23a	a) (Type, F 340	vensvill	e Rd	w	est 1	Ziver,	MD	20778			
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	1 7 2007 Registr	s Signature	K	And	, '			,					

			For State Registrar	State of Maryl		artment rtificate			Re	eg. No.	24669
	D1 -:-:		1. Decedent's Name (First, Middle, La	st)					2. Date of Deat Month	th Day Year	3. Time of Death
	Physici /Medic	al .	Susan McHen 4a. Facility Name (If not institution, giv			4h City To	wa or loc	cation of Death	July	11, 2007	6:30 P M
	Examin	er	1.			, ,					
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1		Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	erick hplace (State or Foreign buntry)
	Director		218-50-2776	□M 2ĬF	57 Yrs.	Months	Days H	lours Min.	Oct. 6,		yland
	pu >		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ncation					10d. Inside City Limits
	shov	5									1 ☐ Yes 2 No
	28a-f	ect	Maryland Frederi	ck	Fred	erick 10f. Zip C	ode		1	0g. Citizen of What Co	ountry?
	with 3a or	0	4701 Teen Barne	s Road			21703	3		United S	tates
	ms 2:	nera	11. Marital Status	12. Was Decedent Ever Armed Forces?	n U.S. 13.				ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	ncan Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ia marked other then "natural", or Items 23a or 28a-f show other traumatic event, Ite Madical Examination used the millied at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X		Брөсіfу:	(((((((((((((((((((White
21215-0036	2 hour	ted t	15. Decedent's E	ducation	16a. Dece	dent's Usual	Occupation	n na most of work		16b. Kind of Business	Industry
215	hin 7: an "n Medi	Completed	(Specify only highest gr.	College (1-4or 5+)	life.	DO NOT use	retired)	ng most of work	arig		
	filed wit Hygiene othar tha	Con	12		H	lomemak				Own Hom	e
Maryland	2 should be filed withir and Mental Hygiene. Ia marked othar than raumatic event, Tie M	Be	17. Father's Name (First, Middle, Last				18		•	Maiden Sumame)	
S	should be to a marked or amaric eve	٤,	Pau1 Hamm 19a. Informant's Name/Relationship (19h Maili	ing Address /	Street and		earinger	r, City or Town, State,	Zip Code)
Mai	d 2 st th and 7 lan traun		James McHenry /			_				ck, MD 217	
	Health tem 27		20a. Method of Disposition		b. Place of Disp	osition (Name	of			20c. Location - City or	
Ö	Pages nent of I ant: If Its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, cre Mt. Oliv	-		7/18	/2007	Frederick,	Maryland
Baltimore,	_ E E E		21. Signature of Funeral Service Lice			2. Name and				Funeral Ho	
ä	permi Depar Impor any ir		Yourtney S	tauffer	72					ederick, M	D 21702
	Physician		231. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	plication what caused the one cause on each line.	death. Do not en	ter the mode	of dying, s UNO	./1	or respiratory arr	est,	Approximate Interval Between Onset and Death
4	/Medical		resulting in death)	Due to (or as a cor	sequence of):		00.00		1.07.0		J 1
	Examiner	_	Sequentially list conditions,	b. — Due to (or as a cor	acoguanaa at):						
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ds, P.0	ires that t signed by d be deta	d by Ph	Part II. Dther significent conditions	entributing to death but no	t resulting in the	underlying cau	ıse given i	n Part I.	23e. Did to	bacco use contribute t es 2 ⊠No 3 □ P	o the cause of death?
Records,	w requ been shoul	lete		4 0 0 0					24a. Was a	an 24b. Were a	utopsy findings available completion of cause of
Re	The lar	Jung							autop: perfor	med? prior to death? 2 No 1 Yes	
Vital	an: T tificat tor, pa	a)	25. Was case referred to medical				26	6. Place of Dea	th (Check only or		
Ž	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA	Other:	4 Nursing H	ome 5 Resid	ence 6 Other (Spe	ecify)
n of	fter me	:uo	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time (c. Injury at Work?		28d. Describe h	ow injury occurred	
sio	Attanding ir death. ector; After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not		A1 have farm	M		2 □ No	28f Location /S	treet and Number or F	Jural Route Number
Division	after c	Certification:	4 Homicide determined	building, etc. (S)	pecify)	treet, ractory,	OHICH		City or Tow		
_	To the Hospital or Attandii within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exa	hysicien: To the best of my miner: On the basis of exa and manner stated.	knowledge, dea mination and/or i	th occurred at nvestigation, i	t the time, n my opini	date and place on, death occu	, and due to the c rred at the time, c	cause(s) and manner a dato and place, and du	s stated. e to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	111.		29c.	License л	umber	2	29d. Date signed (Mon	th, Day, Year)
			11/09	Me M.	D,	D	005	4911		07-12	-2001
	10		30 Name and address of person who	Erlich-21	(Item 23a) Type	BEIVE	der	e Ave	. BAHi	MORE MI	2/2/5
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 9	2007 32. Repistrar's S	signature	pode					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Mai Fand? Departments 70e att 2and Medital Hygiene Certificate of Death Reg. No. 2. Data of Death Decedent's Name (First, Middle, Last) Year **Physician** 7727/2007 9:35 <u>Barbara Lee Mock</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick North Hampton Manor If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 21 F 6/12/1935 MD Director 214<u>-36-0778</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If time 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 1 XYes 2 No Director Frederick MD Frederick 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21702 538 Lee Place Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2√ No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None 12 None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Herman Mock Edna Anna Mary Riddlemoser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8123 Stone Ridge Dr. Frederick, MD 21702 Rose Marie Fitzpatrick 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/31/2007 Frederick, Maryland Mount Olivet Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Keeney & Basford P.A. F.H. 106 East Church St. Frederick, MD 21701 M01176 23a Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coliffs **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes You No 26. Place of Death (Check only one) Be Other: Hospital: 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specity) 2 ER/Outpatient 3 DOA 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death al or Attending P s after death. al Director: After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i the Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bamas State Registrar

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica

State

DHMH 17 Rev 1/2001

(Check only one)

or wasecona

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007▶

Dalvi

310 HUSPITAL

32. Registrans Signature

RM

29c. License number

D0064961.

29d. Date signed (Month, Day, Year)

PRINCE FREDERICK IND 20678

07-05303 Caroline Niland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aroline Niland	1.	State of Maryland / Department of Health and Certificate of Death	d Mental Hy		, No.	07 2467
Dhyminian	Re	Decedent's Name (First, Middle,Last)		2 Date of Death	j. No.	3. Time of Death
Physician ledical Examine		Carrie Caroline Niland		Month July 10, 20	Day Year 07	1458 hrs
pt .6.	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or			40. Godiny or De	eath
		Calvert Memorial Hospital Prince Fred		To Date of Birth	Calvert	Birthplace (State or
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day			I E o	roign
Director	5	78–26–9192 1 M 2 X F 91 Yrs. Months		10/13/	1915	Country) Washington
e e	_	sual Residence of Decedent 0a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ž "	М	aryland Calvert Lusby	.,			1 Yes 2 X No
Maryland 28a-f show	<u> </u>	De Street and Number 10f. Zip Code			g. Citizen of What C	
uth the Maryland 23a or 28a-f sho	2	13280 Joy Road 20657	7		United St	ates
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examinar must be notified at once		1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spanic Origin?)	pecify Yes or No-	14. Race - Ar White, et	merican Indian, Black,
death rr iten	runera 1	Never Married 2 Married 1 Yes 2 X No		, , , , , , , , , , , , , , , , , , , ,		
after all, o	اح	3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No ro Pates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa		work done	Specify: wh	
hours		during most of working life	e. DO NOT use ret	ired)		
)36 thin 72 ne. than "	Be	Selementary/Secondary (0-12) 9th College (1-4 or 5+) homemaker			own home	
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Completed	7. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, N	Maiden Surname)	
21215-00 uld be filed with Mental Hygien marked other c event, the M	Ř	Lawrence Schreiber	Minnie	Unkno		
hould the hould	0 1	9a. Informant's Name/Relationship (Type, Print)				
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. raut: If iten 27 is marked other than "natur or other traumatic event, the Medical Exam	- 1-	incent E. Niland - son 831 Sandpiper			Beach NC 20c. Location - Cit	ty or Town, State
ore, MC es 1 and 2 s of Health at If item 27 ther traums		20a. Method of Disposition 20b. Place of Disposition (Name of cerematory or other place) Removal from State			Solarans M	
Page Page ment claimt:		4 Donation 5 Other Specify: Cur Lacy Star Of the		<u> </u>	1	
Baltimore, permit. Pages I at Importante of He Important. If He injury or other tr		21. Signature of Education	Rau	isch Funer	al Home	
	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	Ts rd Pc g, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Physician I	-	failure. List only one cause on each line.				Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
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0, the execut sician and burial - tra	edical	UNPENDED AMENDED			23d. Date of de	elivery
876 ifficate	⋛ 2	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregr	nancy	Month	Day Year
Box 68760, e death certificate be the attending physic effor use as the burned	sician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)				
Box 6876(ne death certificate the attending physhed for use as the be	>	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
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Gyuires quires en sig	ted			24a. Was		ere autopsy findings available or to completion of cause of
cords,	Completed				rmed? dea	ath?
tal Rection: The certificate	5	26 Pla	ice of Death (Chec	-	2 V No 1	Yes 2 No
Vital Rec ysician: The I his certificate i	å	examiner? Hospital: 1 Innation 2 FR/Outpatient 3 DOA	Othory	sing Home 5	Residence 6	Other:
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. The Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	앍	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. In	njury at Work?	28d. Describe	how injury occurred	1
on C anding arh. rr. Af	틶	Natural 5 Pending	Yes 2 No			
r Atto ter der irecto n by t	liga	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	e building, etc.	28f. Location (or Town,		or Rural Route Number, City
Divoltal o	Certification:	4 Homicide determined (Specify)		-		
Hosp 24 ho Fund etely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opini	date and place, a	nd due to the cau	se(s) and manner a and place, and due	s stated. e to the cause(s)
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the b	Medical	and manner stated.	ense number			i (Month, Day, Year)
	Σ	29b. Signature and title of certifier	C.M.E.		July 11, 200	
		Call of Hallett				
1		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltin 	more, MD 212	201		
St.	ate	Catery man, ma				
Regist		31. Date filed (Month, Day, Year) 6 2007 32. Rigistrar's Signature				

07

666 Matthew C		Please Type or Print in Black indelible in ca State of Maryland / Department of For State Certificate of	Health and Mental Hy	giene 2007 2457
Die :	R	edistrar . Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death
Physicia al Examii	ner	David Matthew Oszajca	4b. City, Town, or Location of Death	Month Day Year 1004 hrs July 24, 2007 4c. County of Death
		ta. Facility Name (if not institution, give street and number) Calvert Memorial Hospital	Prince Frederick	Calvert
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 213–19–5436 1 X M 2 F 23 Yrs	Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Dec 9 1983 Merryland
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ion	10d. Inside City Limits
* .≅	ā	Maryland Calvert Port Repu	blic	1 Yes 2 No
the Mary a or 28a- iffied at	Director	10e. Street and Number 4136 Oakdale Lane	20676	United States
after death with the Maryland al", or items 23a or 28a-f sh- iner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	as Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto F	acify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. white Specify:
urs urs	2	15. Decedent's Education (Specify only highest grade completed) 16a. Deceded during a	nt's Usual Occupation (Give kind of wonest of working life. DO NOT use retin	ed)
uld be filed within 72 l Mental Hygiene. marked other than " c event, the Medical I	Completed	12 sales	19 Mother's Name	(First, Middle, Maiden Surname)
uld be filed within 72 ho Mental Hygiene marked other than "na event, the Medical Ix	Be	17. Father's Name (First, Middle, Last) Robert Oszajca	Aurora M	Magallanes
2 should I and Mer 27 is man	٦ 1	Robert Oszajca – father 4136	Oakdale Lane Port	tural Route Number, City or Town, State, Zip Code) Republic MD 20676
es 1 and of Healt! If item		crematory or o	sition (Name of cemetery, ther place) Vianney July 27 2	Date 20c. Location - City or Town, State 2007 Prince Frederick Mary
permit. Pages I an Department of Hea Important: If iter injury or other tr		4 Donation 5 Other Specify: 21. Signature of Foreral Service Licensee 22.	Name and Address of Facility Ra	ausch Funeral Home
ii.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	05 Broomes Is. Ro	Port Republic MD 20676 respiratory arrest, shock, or heart Approximate Interval
aminer	aminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
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certificate be ending physici use as the buri	cian/Med	##.Z.4, 21, 204 1, petric, st IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2	Fetal death 3 Ectopic pregn: Other (Specify)	23d. Date of delivery Month Day Year
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To the Hospital or Attending Physician: The Jaw requires that the death within 24 hours after death. To the Verneral Director: After this certificate has been signed by the stiff To the Verneral Director: After this certificate has been signed by the stiff commerce of the first part of the first has been signed by the stiff the part of the first part	Completed b			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
The la			26.Place of Death (Check	1 Yes 2 No 1 Yes 2 No
sician: s certif irector.	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatie	1Othor:	
ing Phys After thi funeral d	2 2 2	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending T 1 7/2/ (2007 To 4 Oct.)	1 Ves 2 V No	28d. Describe how injury occurred
or Attend fiter death Director:	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be	treet, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 4331 Williams Wharf Rd. St. Leonard
Hospital 24 hours a Funeral I	al Cert	4 Homicide determined (Specify) found in house 29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death or	gusted at the time, date and place, an	d due to the cause(s) and manner as stated.
To the within ?	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	gation, in my opinion, death occurred 29c. License number	29d. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier Donna M inconti, mid.	O.C.M.E.	July 25, 2007
y		30. Name and address of person who completed cause of death (Item 23a)	11 Penn Street, Baltimore, I	MD 21201
	State	Doniel IV. Viriodita, IVID		
Regi		0.0.007	Af. ×	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Barbara Lee Pirie 2236 06 8 07 /Medical 4a/Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL LENTER ALISBURY Wicomico EGIONAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 😿 F Months Days Hours Min 10/7/1933 217-30-9643 73 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentel Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 S. Schumaker Dr., Apt. 304 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specifie hite Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Smullen Edgar Rayne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 S. Schumaker Dr., Apt. 304, Salisbury, MD21804 Dr. Donald Pirie/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial 6/21/07 Salisbury, MD Park ²² Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral \$ervice kicensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTRA CRANIAL BLEED **Physician** /Medical Examiner NYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? 2 40 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 □ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 □Pending М 1 ∏Yes 2 ∏No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

24 hours after death e Funeral Director: To the

State Registrar

DHMH 17 Rev 1/2001

Medical

29a, Certifier

29b. Signature and title of certifier

NEMAL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1005HI

and manner stated.



ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

106 MILFORDS T, SLUTE 504B SAUSBURY

29c. License number

763433

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:07 PM OWELL 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Tracys Landing Anne Arundel 6136 McKendree Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 ■ F 218-36-6707 94 Maryland Aug 16, 1912 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Anne Arundel Tracys Landing Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 20779 6136 McKendree Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2XNo Baltimore, Maryland 21215-0036 Specify Specify: Black þ 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M once. Church Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Annie Taylor William Wilkerson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 3 Sunderland, MD 20689 Beatrice Riggs /Niece Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 07/18/07 Lothian, MD Union UM Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sewell Funeral Home Placks 1451 Dares Beach Road Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 TYes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural s after dea... ral Director: Aftr 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 005158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

INF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Charlotte Lynn Poletynski 2007 2467 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 25, 2007 1156 hrs Charlotte Lynn Poletynski **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Dundalk 8105 Delhaven Road 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number **Funeral** oreign CountrMaryland Months Hours 1/15/1965 Director 42 220-88-6244 M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Yes 2 X No Dundalk MD notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21222 8105 DelHaven Road 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married 2 X No Yes If Yes, Give Year Yes 2 X No specify: Specify: White Widowed Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) within 72 Bour Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I other than "I In Home Homemaker 12 2 should be filed within h and Mental Hygiene.
27 is marked other tha 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 127 is marked o numatic event, tl Roberta Ann Wilkins Richard Donald Barnhart Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, MD 21222 8105 DelHaven Rd. timore, MD Steven M. Poletynski (Spouse) of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a, Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Pages 1 7/31/07 West Chester, PA R. A. Ferris & Co. Donation 5 Other Specify Tarring-Cargo Funeral Home, P.A.

Marvland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician /Medical Death Methadone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical ysician a X UNPENDED AMENDED #23a,27,28a-f, perME,g870, 8/8/07 TT Box 68760 23d Date of delivery attending phys or use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o Yes 2 No 3 Probably 4 V Unknown Completed by Division of Vital Records, P. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? 1 V Yes 2 No Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica Other₄ Hospital: Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 Inpatient 2 this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Natural Yes 2 XNo Pending Director: d in by the f Fnd 7/25/2007 Fnd 11:50 am 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide 8105 Delhaven Road Dundalk, MD determined found at home Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 26, 2007 O.C.M.E. Pn 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day Yea AUG 0 Registrar's Signature State 200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** <u>12:10</u> a^M July 19, 2007 Russell Melvin /Medical Joseph 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Evaminer St. Mary's St. Mary's Nursing Center
5. Social Security Number 6. Sex 7 Leonardtown Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 83 10/14/1923 Maryland Director 217-14-2936 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 💢 No Director Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20650 United States 41075 Paw Paw Hollow Lane by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🎇 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marine Diesel Mechanic Civil Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M Stone Wilson Russell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 23, Leonardtown, Maryland 20650 Barbara Russell/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cr. 07/21/2007 Charlotte Hall, MD 21. Sign that of Funeral Service Licent 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward W. Brinsfield, x100052 22955 Hollywood Road, Leonardtown, Maryland 20650 Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and De Immediate Cause (Final resulting in death) Due to (or 34 a or Sequentially list conditions, any bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Tyes 2 No 9 Unknown 9 Unknown

Physician /Medical Examiner

> as the attending

nse

Por

The law requires that the death certificate be executed Records, P.O. Box 68760.

the Maryland

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23: Iry or other traumatic event, the Medical Examiner must

permit. Pages 1 Department of H Important: If ite any Injury or ot

Baltimore, Maryland 21215-0036

Physician/Medical Examiner þ Completed Be ۴ Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

26. Place of Death (Check only one)

perform 29 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

24a. Was an autopsy Were autopsy findings available prior to completion of cause of death? 2□No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

1 Inpatient Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of 1 ☐ Yes 2 ☐ No

Other:

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 D Accident

3 ☐ Suicide 4 ☐ Homicide

> @ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death?

1 Tyes 2 No 3 Probably 4 5 Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James P. Jarboe, M.D. 24035 Three Notch Road, Hollywood, MD 20636

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 2 8 2007



ORIGINAL

Division or Vital

To the Hospital or Attending Physician: within 24 hours after death.

this

Director:

within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:02 PM Jean 19 Reed 2007 Florence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1□M 2XX **Funeral** 216-74-7106 Maryland Oct. 28,1935 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location a or 28a-f show the notified at 10a State 10b. County 1 X Yes 2 No Director Boonsboro Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 19 Schoolhouse Ct. 21713 USA or items 23a the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Mary Catherine Timmons Elmer Paul Charles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 3835 Chestnut Grove Rd. Keedysville, Maryland 21756 Joyce Funk - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park July 24,2007 Hagerstown, Maryland 4 ☐ Donation 5 Other (Specify, GSBOP ne Afform er Feilty Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed attending physician and for use as the burial-transit TNEARCTION Box 68760. MYOCARDIAL Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Were autopsy findings available prior to completion of cause of 24a. Was an ate has l performed PAILURP 2 No OLITIC certificate 2 No 25. Was case referred to medical examiner? or Attending Physician: 26. Place of Death Check onl one Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred uneral 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: Al
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier fonth, Day, Year) State JUL 2 0 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 July 11, 11:00 PM Theresa Pecola Reid 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Crescent Cities Center Riverdale If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 1 □ M 2 🙀 F 230-07-8906 90 05/08/1917 Carolina Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Washington 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 1509 Benning Road, S.E. K33 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Self 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Benson Maggie Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valeria Smith - Daughter 1509 Benning Road, SE #K33: Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem 07/19/2007 Suitland, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee Kendamfreemar 4594 Beech Road; Temple Hills, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final ANTERIOSEL y-enu resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 → NO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No nedical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If Ite any Injury or ot

Physician

/Medical

Examiner

DC

Director

Completed by Funeral

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

as the burial-tran

Examiner Completed by Physician/Medical Certification: To Be

and signed by this After To the nosponse within 24 hours after death.

To the Funeral Director: Aft

or Attending Physician: The law requires that the death certificate be executed

To the Hospital

Division or Vital Records, P.O. Box 68760,

25. Was ca examin 1 \(\superset \) Ye	ier?	to n
27. Manne		
2 Ac		

3 ☐ Suicide

29a. Certifier

4 Homicide

Pendina

investigation 6 Could not be determined

1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Sign	ature	and	title	of	certifier	

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

BJ

DHMH 17 Rev 1/2001

Medical

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUL 1 8 2007

32. Registrar's Signature

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in	1. Decedent's Nam Joseph I	, _		,							2. Date of D Month July		Day 2	Year 2007		Time of Deat
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d	5. Social Security		6. Se		Age (In yrs	a. last birthday,	If Under	1 Year	If Under 24		8. Date of Bi	irth		9. Birt	thplace	(State or For
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Director	MD	Anne	Aru	ndel ———	A	nnapol									L	□Yes 2X
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ToB	Joseph I										Witti					
	19a. Informant's N										Route Numi				Zip Coa	le)
	20a. Method of Dis		-/ ''		20b.	Place of Disponentery, cre	osition (Nam	e of		Da	ate		Location		Town,	State
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State

Registrar

of death (Item 23a) (Type, Print)
900 Bestepit Road #300 Anner-ins, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 July 11, РМ 9:11James M. Silvers 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Queen Anne's 310 Irene Way Stevensville 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 1955 New Jersey 5. Social Security Number 8. Date of Birth (Month, Day, Sept. 7, 7. Age (In vrs. last birthday Days 51 215-62-5899 Sept. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Maryland | Queen Anne's Stevensville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21666 310 Irene Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Department Prince George's Policeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Marie McNamara Frederick H. Silvers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Irene Way Stevensville, MD 21666 Mary Silvers/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 7/17/2007 4 Donation 5 Dother (Specify) Davidsonville, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on e. ch line. Part1. Enter the disease, shock, or hear failure. I Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical **Examiner**

Department of Health ar Important: If Item 27 is any injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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23a

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'natural"

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and Mental Hygiene. is marked other than

the Medical

must be notified

Directo

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician this After Director: in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical by Completed Be Certification: To

within 24 hours a To the Funeral I completely filled To the State

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death

Medical

1 TYes

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death 9 Unknown

Due to (or as a consequence of)

5 ☐ Other (specify)

3 □ Ectopic pregnancy

23d. Date of delivery Month

Day Year 23e. Did tobacco use contribute to the cause of death?

2 No 3 Probably 4 Unknown

24a. Was an autopsy performe Yes 2

1 🗌 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

28c. Injury at Work?

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sigpature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

completed cause of death (Item 23a) (Type, Print) 1650 ORASTIERE MO

Hospital:

ORLEAUS ST, BALTIMORE MD231

31. Date filed (Month, Day, Year)

JUL 1 6 200

32. Regionar's Signature

Registrar

		1	For State Registrar	State of Ivia	ıryıand	•	artment of H rtificate of L		_	Glerie Reg. No.	2007	24683
			Decedent's Name (First, Middle, L.)	ast)					2. Date of De Month	ath Day	Year	3. Time of Death
	/sicia ledica	al	Louise	Thompson	Sc	chneic	der		07	15	2007	0532AM
	amine	-	4a. Facility Name (If not institution, ga		0	O		Location of Death		,	County of Death	
				NAC MEDICA Sex 7. Age	(In yrs. las	UTER.	If Under 1 Year	BURY If Under 24 Hrs.	8. Date of Bir	th)? COM CO	ace (State or Foreign
Fune Direc			207-07-7821		7	Yrs.	Months Days	Hours Min.	(Month, Da 2/16/1	ay, Year)		sylvania
land	-	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation				10	d. Inside City Limits
Mary -f sho	leda	ţō	Maryland Wicomi	.co	Sh	narpto	own					1 KYes 2 □ No
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th wit	nst be		507 Railway				21861			US.		
er dea	n n	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Pu <i>e</i> rto	ecify Yes or No Rican, etc.)	D- 1	 Race - America Black, White, e 	
s 1 and 2 should be filed within 72 hours after death with the Maryland s 1 and 2 should whental Hygiene. Health and Mental Hygiene.	Examir	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10		1 □ Yes 2 No	Specify:			Specify: wh	
72 hc	dica	Completed	15. Decedent's (Specify only highest g	Education rade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	ing	16b. Kin	d of Business/Ind	ustry
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ld be lental	ic ev	To Be	George Thompsor	1				Dorothy	/ Maitla	and		
s mar	nmat nmat		19a. Informant's Name/Relationship				ng Address (Street				Town, State, Zip	Code)
and 2	er tra		Robert Schneide	er/son			Railway,				Oit T-	Obsta
			20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3	☐Removal from State	1		osition (Name of matory or other place	1	Date		eation - City or To	
t. Pa tmen tant:	Jury		4 □ Donation 5 □ Other (Spe	cify)	Sal:		y Cremato				isbury,	
permit. Page Department Important: If	any lr	a h	21. Singerure of Funeral Service	200		- 9	Holloway 501 Snow	Funeral H Hill Rd.,	Home Pro Salish	ofess bury,	ional As MD 2180	sociation 4
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each li	the death.	Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
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peq	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque							
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ath ce	or use	sician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	□Ectopic pregnanc	у		2	23d. Date of delive Month	ory Day Year
The law requires that the death certinate has been signed by the attending	thed fo	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of dea	atn 5	☐ Other (specify) _					
that t	detac	/ Phys	Part II. Other significant condition	s contributing to death b	ut not result	ting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to the	ne cause of death?
quires an sign	ad blu	d by							1 🗆	Yes 2	No 3□ Prob	ably 4 Unknown
aw rec	2 shou	Completed							24a. Wa	s an opsy	24b. Were auto	psy findings available mpletion of cause of
The lav	page	mo							per 1⊡ Yes	formed? 2 No	death? 1 ☐ Yes	
cian: ertific	ctor,	Be C	25. Was case referred to medical examiner?	11			Lou	26. Place of Dea	th (Check only	one)		
Physic r this c	al dire	²	1 Yes 2 No	Hospital: 1 Phopati		R/Outpatie	IN SOLDOA		ome 5 ☐ Res 28d. Describe		Other (Specif	y)
dling F	funer	jon:	27. Manner of Death 1 Natural 5 Pending 2 Perident investigat	(Month, Da		Injury	Wo	rk?]Yes 2 □ No	200. Describe	s now injur	y occurred	
Atten death ctor:	y the	ficat	3 Suicide 6 Could no	be 28e. Place of in			treet, factory, office		28f. Location	(Street an	d Number or Rura	al Route Number,
alor safter	d in b	Certification:	4 Homicide determin	building, e	tc. (Specify)				City of Ti	own, State	,	
DIVISION OF VICE TREE To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he	etely fille	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best caminer: On the basis of and manner st	of examinati	rledge, dea on and/or i	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to thurred at the time	e cause(s) e, date and	and manner as s d place, and due t	tated. o the cause(s)
To the within To the	ф	Me	29b. Signature and title of certifier				29c. Licens			29d. Dat	te signed (Month,	Day, Year)
2	1/2		1 Ch	ha			_ h	205615	7	7	15/200	7
O'	5		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type	Print) Robe	2184)				
.≅ Pr	Sta egisti		31. Date filed (Month, Day, Year)	2007 32. Regist	rar's Signat	ure	Small .					
	Siett	451	001 10		J. 6.50	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [20] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:20 PM Ø. 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vicomico If Under 24 5. Social Security Number Hrs. 8. Date of Birth
Min. (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😿 F 89 Director 215-32-8061 11/2/1917 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2√ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Tressler Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: Army 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Hickman Archie Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 is
any injury or other trau 600 Tressler Dr., Salisbury, MD 21801 Harry S. Shinton, Jr/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Salisbury Crematory 7/17/07 Salisbury, MD 21. Signature of Funeral Service Licensee 22 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Held 11 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 6 mos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has autopsy performed? certificate Vital 2 🖪 No Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ု 1 ☐ Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
7 To the Funeral Director: All completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRYDR, SALISBURY, MD 21801 31. Date filed (Month, Day, Year)

State Registrar

JUL 1 8 2007

32. Registrar's Signature

ORIGINAL

			1 - For State Registrar	State of Mary		artment of Healt <i>rtificate of Dea</i>		, ,	ene g. No.	
1	Physici	an	1. Decedent's Name (First, Middle, Last				2	Date of Death Month	Day Year	3. Time of Deathp
	Physici /Medic			ingen-Packa	ard			July 15	, 2007	12:00 ^M
	Examir	er	4a. Facility Name (If not institution, give	_		4b. City, Town, or Local	ition of Death		4c. County of Death	~~
	C		34 Sandy Hook Ro 5. Social Security Number 6. Se		'n yrs. last birthday)	Berlin If Under 1 Year If Un	nder 24 Hrs. g	Date of Birth	Worceste 9. Birthp	lace (State or Foreign
	Funeral Director		579-48-6361	□M 2⊠F 72	Ven	Months Days Ho	urs Min.	(Month, Day, 1 12/1/19		ington, DC
	/land		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation			1	0d. Inside City Limits
	Ba-fet	Director	Maryland Worcest	er	Berlin					1 ¥Yes 2 No
	with th	Dire	10e. Street and Number	-		10f. Zip Code			g. Citizen of What Cour	ntry?
	ne 23	era	34 Sandy Hook Roa	12. Was Decedent Eve	er in U.S. 13. \	21811 Was Decedent of Hispani	ic Origin? (Specif		USA 14. Race - Americ	an Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow or other traumatic event, the Madical Examiner must be mailtied at	by Funeral	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	Was Decedent of Hispani f Yes, specify Cuban, Me 1 ☐ Yes 2 ☐ No Spe	ecity:	can, etc.)	Black, White,	
21215-0036	2 hou	ted	15. Decedent's Edi	ucation	16a. Deced	dent's Usual Occupation	most of working	16	6b. Kind of Business/In-	
215	within 7 ene. then "n	Completed	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done during DO NOT use retired)	most of working			
	filed wi Hygien ther th		12	2 1/2	Execu	tive Secreta			S Governmen	nt
Maryland	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the Ma	Be c	17. Father's Name (First, Middle, Last) Eugene Woodside				Mother's Name (i			
iry	should be find Mental His marked of	2	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Street and N	_		=	Code)
	and 2 alth a 127 fe er tra		Raymond D. Sweari	.ngen/son	34	Sandy Hook	Rd., Be	rlin, M	D 21811	
ore	of He of He H Item or oth		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place of Dispo cemetery, crer	sition (Name of matory or other place)	Dat	9 20	Oc. Location - City or To	own, State
Baltimore,	t. Pages dment of dent: If It		4 □ Donation 5 NOther (Specify,)	-	ifts Regist	- T		Glen Burnie	
Bal	permit. Pages 1 and 2. Department of Health ar Important: If Item 27 is any Injury or other trau 2008.		21. Signature of Funeral Service Licen	uce (FIB) 第 5	Name and Address of Followay Fund Ol Snow Hill	eral Hom l Rd., S	e Profe Salisbur	ssional Ass y, MD 2180	sociation 4
E	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the	e death. Do not ent	er the mode of dying, suc	ch as cardiac or r	espiratory arres	st.	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a c	onsequence of):	27 411	110010311	1015		D. yeurs
V.,	Examiner	L	Sequentially list conditions,	b						
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence or):					
Ć.	execu in and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
68760,	rificate be executed og physician and as the burial-transit	edical	(d						
_	entification plans plans to as t		IF FEMALE:	23c. If yes, outcome of	oregozoov					
Box	that the death certif ed by the attending detached for use as	Physician/M	in the past 12 months?	1 Live birth 2 [4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
0	hat the d by ti		9 Unknown Part II. Other significant conditions co		not reculting in the u	nderhing cause given in I	Dart I	23e Did toba	acco use contribute to the	ne cause of death?
Records,	w requires that the been signed by th should be detache	ed by	Partii. Other significant conditions of	intributing to death but i		ndenying cause given in a	raiti.	1 Yes		pably 4 Unknown
eco	> 11 (2	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
Ξ Ξ	The ete h page	Con	v 1)					performe 1 ☐ Yes 2	ed? death?	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Othor	Place of Death (
of	Phys r this ral dir	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ∐ Inpatient 28a. Date of Injury	28b. Time of	11 3 DOA 4			ice 6 Other (Specification)	y)
lon	Attending r death. ector: Alter by the fune	ation	1 Matural 5 Pending 2 Accident investigation	(Month, Day Y	'ear) Injury	28c. Injury at Work? M 1 Tyes				
Division	I or Atteather designation Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)	eet, factory, office	28	f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of r iner: On the basis of ex and manner state	camination and/or in	n occurred at the time, da vestigation, in my opinion	ate and place, and n, death occurred	d due to the cau at the time, dat	use(s) and manner as s e and place, and due to	tated. o the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manifel s(8)(6)		29c. License num	nber	296	d. Date signed (Month,	Day, Year)
	- 3 F 3	1	1/2/11/2	100 MD		0-35	764		7/1/0/	2001
•	1.92		30. Name a address of p n who c	ompl ed cause of deat	th (Item 23a) (Type,	Print)	1	A 1	17 100	cayind.
-	10		Bill Green	MD 1	2417.	SuiteSH 1	U Clan	Gratewi	ay Ocean	City, Ma.
To the	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	hand a			7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 15, **Physician** 2007 0830 John Edward Schaeffer, Sr. July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford 667 Trimble Road Joppa Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 11XM 2□ F Yrs. 1929 508-20-6578 78 June 11, Nebraska Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 ☑ No Harford Director Joppa Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21085 667 Trimble Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or iter 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1948-68 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3K Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bainbridge Naval Training Ctr. College (1-4or 5+) Elementary/Secondary (0-12) Bainbridge, Maryland Chief Petty Officer Two 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Edward Schaeffer Amy Adair 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anne M. O'Connor (daughter) 667 Trimble Road, Joppa, Maryland Important: If item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/17/07 West Chester, Pennsylvania R.A. Ferris & Co., Inc. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Sign ture of Funeral Service Lice see JEMON SC Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardino respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NONG disease or condition resulting in death) ave /Medical Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and the burial-tran Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe (1 | Yes 2 | No 3 | Probably 4 | Uniknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? page 2 certificate 2x No 25. Was case referred to medical director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

death with the Maryland

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and title of certifier 29b. Signature

ne and address of person who completed cause of death (Item 23a) (Type, Prin

29c. License number

29d. Date signed (Month, Day, Year)

o+IVA

within 24 hours a To the Funeral I

completely

State Registrar

30 🐲. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Virginia Englar Strohminger p^{M} July 13 2007 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 H Months | Days | Hours | Mi 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 ⋤ F 216-10-0800 Usual Residence of Deco-Director Mar 24 1913 MD 94 Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Counfy 1 TYes 2 No Westminster Carroll Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 300 St. Luke Circle 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 250 If Yes, Give Year or Dates: 25 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ု Alma Myers John Addison Englar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1237 Weller Way Westminster, MD 21158 Mary K. Newcomb/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 07/16/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead, MD Carroll Cremation, Inc 4 Donation 5 Dother (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 2 1No 1∐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 ☐ Yes 2 ☐ → 16 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier

WIL 3

> State Registrar

d address of person

31. Date filed (Month, Day, Year) 16

Hosain

32. Registrar's Signature 2007

who completed caus of death (Item 23a) (Type, Print)

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Ham It westwinster HD 2015 7

07-05435

Amended Item 19b per F.D. 07/18/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert G. Sparkma			ate of	Maryla	nd / De	epart	ment of ficate of	Health	and	Menta	al Hygi			6	00	17 24	58
	Re	For State egistrar Decedent's Name (First, Midd	le Leet)			erui		Dealii			2.	Date of De	Reg. No eath		1	3. Time of Death	
Physician Medical Examine		Robert G		parkı	nan						J	Month July 15,	Day 2007	Year		2150 hrs	
Medical Examine	4	a. Facility Name (if not institution	on, give str	eet and nu	mber)		4	b. City, To		ocation of	Death		4	c. County of	f Death		
		4 York Street Apt. 16						Taneyt			- 01 Lo	Data - (1	L	Carroll	0 Birth	nplace (State or	
Funeral	5	Social Security Number	6. Sex	- 1	7. Age (In		birthday)	If Under Months	1 Year Days	If Under Hours		Aug 2			Foreigy	aryland	
Director	12	212-62-3645	1 X M	2F	5	51	Yrs.					Aug 2	.5,	1755			
		Usual Residence of Decedent Oa. State 10b. County			10c.	City, To	own or Locati	on								10d. Inside City Li	
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or 28	Director	4 York Street	Apt 1	16						2178		- 2			SA ——		
		1. Marital Status		2. Was Dec	cedent Ever	r in U.S.	. 13. Wa	s Deceden	t of Hisp Cuban.	anic Origi Mexican,	in? (Spec Puerto Ri	cify Yes or can, etc.)	No-	14. Race White		can Indian, Black,	- 1
death rr iten	Funeral	1 Never Married 2	1 1	Yes	2			Yes 2						Specify:	wh	nite	Ì
after	ğ-	3 Widowed 4 XD	ivorced If	Yes, Giv1e 05e Dates:	73-198	30 ed) L	16a Docodor	r'e Henal C	occupation	nn (Give k	and of wor	rk done	16b	. Kind of Bu	isiness/l	ndustry	
hours natur	ted -	15. Decedent's Education (Sp Elementary/Secondary (0-12			1-4 or 5+)	eu)	during m	ost of work	ing life.	DO NOT	use retired	d)				-ioning	0.00-1
36 nin 72 e. than '	e l	Elementary/Secondary (5 12	'	g- (2	Ì	Ship	oping								ioning	100
21215-0036 Uld'be filed within 72 hours after Mental Hygiene. marked other than "naturyl". ceyent, the Medical Examine:	Completed	17. Father's Name (First, Midd	e, Last)						1			First, Midd Ce Sm		en Surname)		
215 be file ntal H rked o	e l	Delmar Spai					T	Catoo	tan.					MIR OF	L Stat	MD, 21788	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Méntal Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	٩	19a. Informant's Name/Relatio					196.3Mailin	Catoo	tin	High	land	Cr,	The	rmint	, M	21788	
Baltimore, MD semit. Pages I and 2 skd Department of Health and Important: If item 27 is injury or other traumat injury or other traumat		Linda Jensei	1, 51	Scer		20b. P	lace of Dispo		_			Date	20	c. Location	- City or	Town, State	-
Ore, es la of He If ite	П	1 Burial 2 Cremat	on 3	Removal	from State	Pos	ematory or o st Hav	ther place) en Me	m Gá	ard	7/19	9/200	7	Frede	ric	k, MD	
timent rtant:	Ŋ,	4 Dopation 5 Other 21. Sign tu of Funeral Servi	Specify:	10	1961	ICC.	00	Name and	Addroce	of Eacility	Clei	loc F	וסמנו	ral Ho	me		
Balti permit. Departm Importa	-11	11/2 1/1	n .V	10 1	100			136 E	. Ba	altim	ore :	St, I	aney	town,	, MD	21787	
Physician	-	23a. Part I. Enter the disease,	or compli	ation that	caused the	death.	Do not enter	the mode of	of dying,	such as c	ardiac or	respirator	arrest,	shock, or he	eart	Approximate In Between Onse	
/Medical	-	failure. List only one cau Immediate Cause (Final disea	se on each	i jirie.			ascular Di								Щ.	Death	
xaminer	ł	or condition resulting in death		ue to (or as	a consequ	ence of):										
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b D	ue to (or as	a consequ	ence of	·):										
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si.	xar	events resulting in death) La	st D	ue to (or as	s a consequ	ence of):										
0, e be executed /sician and burial - transit	dical	UNPENDED		AMENDE)												
(0, e be e ysiciai burial	ledi	IF FEMALE:			s, outcome	of pregi	nancy							23d. Date	of delive		
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate bin 24 hours after death. After this certificate has been signed by the attending physinpletely filled in by the funeral director, page 2 should be detached for use as the bunched in the page 2 should be detached for use as the bunched with the funeral director, page 2 should be detached for use as the bunched f	Physician/Me	23b. Was decedent pregnant past 12 months?	n the	1 Live	e birth		2 1	etal death		Ectop	ic pregnai	ncy		Month		Day Yea	ar
or use	sicia		Unknown		egnant at tin known	ne or de	ath 5	Other (Spe	ecify)				_				
). BC the de	Phy	Part II. Other significant con	nditions			ut not r	esulting in the	e underlyin	g cause	given in F	Part I.	23e.	Did toba			to the cause of dea	
, P.O. ires that the signed by t	þ											1	Yes			obably 4 🗹 Unk	
ds, equire	Completed											i	Was an autopsy	ì	prior to	autopsy findings av o completion of cau	
of Vital Records, ng Physician: The law requirt After this certificate has been simeral director, page 2 should to	dm												perform Yes 2		death?		No
Retificat		25. Was case referred to me	dical						26.Plac	e of Deat	h (Check	only one)					
Vital Rec hysician: The l this certificate	o Be	examiner? 1 ✓ Yes 2 No		ospital:	Inpatient	2	ER/Outpatie	ent 3	DOA	Other ₄		ng Home				ner: Scene	
on of \rightarrow eath. or: After the funeral	n: To	27. Manner of Death		28a. D. (Me	ate of Injury onth, Day,Yee	or)	28b. Time of	of Injury		ury at Wo		28d. Des	cribe ho	w injury occ	urrea		
Division tall or Attendings after death. ral Director: Alled in by the fu	Certification:		Pending Investigation	on						Yes 2		28f Loca	tion (Str	eet and Nur	mber or	Rural Route Numb	per, City
Divisi pital or Att ours after d teral Direct	tifica	3 Suicide 6	Could not l	28e. F		ry - At h	nome, farm, s	treet, facto	ry, oπice	pullaing,	etc.	or To	own, Sta	te)	(120)		
Di nours aneral		4 Homicide	determined	, ,		lem merel m	dge, death oc	ourred at the	ne time	date and i	place, and	due to th	e cause	s) and man	ner as s	tated.	
Division To the Hospital or Attend within 24 hours after death: To the Funeral Director: completely filled in by the I	edical	(Check only one) 2 Medical	ng Physici Examiner	:On the ba	sis of exam	ination :	and/or invest	igation, in r	ny opinio	on, death	occurred a	at the time	, date ar	nd place, an	d due to	the cause(s)	
To To cor	Med	29b. Signature and title of co		and mann	er stated.					nse numb	er			29d. Date s	igned (f	Month, Day, Year)	-
MSZ	-	11	,/	71	1 ~	,			0.0	C.M.E.	OCM	t		July 16,	2007		
YTIVA		30. Name and address of pe	erson who	completed	ca se of de	ath (Ite	m 23a)		_								
٦.		Theodore M. King	Jr., MD). Ass	istant Me	edical	Examiner	111 1	enn S	Street, E	Baltimor	re, MD 2	1201				
s	tat	31. Date filed (Month, Day,)	(ear)	R	Registrar'	s Signa	ture	de									

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cer	tificate of L	Death		Reg. No.	2007	246	589
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	Year	3. Time of	
	/Medic		JOAN MARIE SEABRIGHT				JULY	18	2007	6:40	A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c.	County of Deatl		
	Euporal	-	GARRETT COUNTY MEMORIAL HOSPITA 5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year	KLAND If Under 24 Hrs.	8. Date of Bir	th	GARR 9, Birth	LII nplace (State o	r Foreian
Ė	Funeral Director		215-38-5164 1 M 2 X F 66	Yrs.	Months Days	Hours Min.	FEB. 7		Con	intry) HINGTON	
	yland yland			, Town or Loc	cation					10d. Inside Cit	ty Limits
	a-f sh	ctor	MARYLAND WASHINGTON		ROH	HRERSVILL	.E			1 □Yes	2 💢 No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citi	zen of What Co	untry?	
	ath w	rall	20528 BENT WILLOW ROAD			21779			USA	-	
	items	Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married	S. 13. W	Vas Decedent of Hi Yes, specity Cuba	ispanic Origin? (Sp n, Mexican, Puert	becify Yes or No o Rican, etc.))-	 Race - Amer Black, White 		
3	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	β	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	☐ Yes 2)(I) No	Specify:			Specify:	WHITE	
5-0036	172 hours after death with the Marylan "natural", or items 23a or 28a-f show alloal Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupa		kina	16b. Ki	nd of Business/I		
7	d within 72 ho giene. r than "natu the Medical	nple	Elementary/Secondary (0-12) College (1-4or 5+)	`life. D	OO NOT use retired)	wig		DED4: 0		
7	filed w Hygie other tl		17. Father's Name (First, Middle, Last)	EXH	IBIT SPEC	18. Mother's Nam	ne (First Middle			OVERNME	.N 1
ang	ntal ed o ed o	9 Be	JOHN EDWARD CULVER			MARY ELL			<i>Surrame</i>)		
Maryland	shound N	J.	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a				r Town, State, Z	ip Code)	
	and 2 ealth a n 27 Is er trau		JERRY T. SEABRIGHT/SPOUSE	20528	BENT WIL	LOW ROAD	, ROHRE	RSVI	LLE, MD	21779	
o.			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	lace of Dispos emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Lo	cation - City or	Town, State	
aitimore,	Pages ment of tant: If its jury or o				LN CEMETI		5/2007	BREN	TWOOD.	MARYLAN	ND.
ga	permit. Pag Department Important: I any Injury o		21. Signature de Paul M. De		Name and Addres				ational		
	40260		23a. Part 1. Enter the disease, or complications that caused the death						Marylan		
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	n Bo Hot Office		-				Approximate Interval Betwood Onset and D	ween Death
	Physician /Medical		disease or condition resulting in death) a. Jue to (or as a consequence)	uence of):	le my	carlia	Pinfa	rely	24		
	Examiner			,	0						
	D #	iner	Sequentially list conditions, if any, isolary cause. Enter Underlying Cause (Disease or injury that initiated events	isnos ut):							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	unnan of							
ŠĆ,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the bural-transit		Due to (or as a consequ	lerice or).							
09/89	ficate physis the	Medical	d								
×	h certi anding use a		IF FEMALE: 23c. If yes, outcome pf pregnant		Cataolia assesses				23d. Date of deli	very	
B0	deat ed for	Physician.	in the past 12 months? 1		Ectopic pregnancy Other (specify)				Month	Day Y	'ear
r Ö	at the	Phy	9 Unknown	.laii.a.la.a	ala di decembra a li co	i- D I	one Did			46	1 - 0
Š	ires the signed	by	Part II. Other significant conditions contributing to death but not resu	iting in the un	ideriying cause give	en in Part I.		robacco u Yes 2[se contribute to ☐ No 3☐ Pro	-	eatn? Inknown
Hecords,	requirements	Completed by	zorga youra						20 20		_
ě	has ge 2 s	mpl					24a. Was auto perfe		prior to death?	topsy findings a completion of ca	available ause of
VITa	sician: The law certificate has l irector, page 2 s		25. Was case referred to medical			26. Place of Dea	1 Yes	2E No	1 □ Yes	2 □ No	
	Physiclan; this certific ral director,	To Be	examiner?	ER/Outpatient	3 DOA Othe	or:			6 □Other (Spec	cifv)	
n or	nding Physician; th.: After this certifica s funeral director, p	n: T	27. Manner of Death 12 Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe				
S S	tendli eath. or: Ai	atic	2 Accident investigation		M 1□'	Yes 2 □ No					
UIVISION	il or Attend after death Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At he building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (City or To	Street an wn, State	d Number or Ru)	ral Route Num	ber,
_	ppital ours a peral I		29a. Certifier 12 Certifying Physician: To the best of my kno	wledge, death	occurred at the tin	ne, date and place	and due to the	Cause(s)	and mainer as	stated	
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	ion and/or inv	estigation, in my o	pinion, death occu	rred at the time	, date and	d place, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License	number		29d. Dat	te signed (Month	n, Day, Year)	
			Perfund		0.	32518		7	-18-0	7	
	×1		30. Name and address of person who completed cause of death (Item	, , , , ,	Print)						
	H-24		Robert Guedenet, M.D. 21 Wya 31. Date filed (Month, Day, Year) 32. Registrar's Signa	nd Driv	ve, Keedy	sville,	Marylan	d 2	1756		
	Sta Registr		JUL 19 2007	4. 1.	all						
				- /4/4							

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death C 0 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:56P M 18 2007 Richard Lee Stanton July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood Nursing Home Williamsport Washington County 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 15 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1923 84 Director 577-22-1318 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Maryland Washington Hagerstown Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 U.S.A. 13632 Overhill Drive 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 🕍 No White Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) National Park Service Superintendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Stanton Charles Stanton ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13632 Overhill Drive Hagerstown Maryland 21742 Sarah J. Stanton wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery July 23 07 Parsons W. Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ntul Cunena /Medical Due (or as a consequence of): **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diay to for as a consequence of: Examiner requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 Abo 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed' after death. Director: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA ို funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 HNatural 5 Pending investigation Injury 1 Yes 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral (🗔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

11-4

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of pers

29b. Signature an

32. Registrar's Signature

on who completed cause of death (Item 23a)

29c. License number

29d. Date signed (Mgnth, Day, Year)

ORIGINAL

			For State Registrar	State of	Marylar		artment o			fental Hyg	iene _{eg. No.}	07	2469	2
	Physici		1. Decedent's Name (First, Middle Lelia Catherin		TZ					2. Date of Dea Month	Day	Year	3. Time of Death	h M
	/Medio Examir		4a. Facility Name (If not institution	, give street and num		· · · · · · · · · · · · · · · · · · ·	4b. City, Tow	n, or Location	of Death	July 1	8, 2007 4c. County		15:10	
	Funeral		226 Nottingham 5. Social Security Number			last birthday) Yrs.	If Under 1 Y	agerst Bar If Under Bys Hours	er 24 Hrs.	8. Date of Birth (Month, Day June 14	Wash:	9. Birthi	place (State or Fore	eign
	Director		219-36-4635 Usual Residence of Decedent 10a. State 10b. County		85	ity, Town or Lo	ocation			June 14	+,1922		ryLand Od. Inside City Lim	nits
	death with the Maryland ims 23e or 28e-f show	ector	Maryland Was	hington		Hage	rstown	40			On Cirina at 18		1 🖾 Yes 2 🗍	
	h with	al Dir	226 Nottingham	Road			10f. Zip Cod	1740		'	0g. Citizen of W	vnat Cou	питу г	
036	2 should be filed within 72 hours after death with the Marylan and Manthal Hygiens and Manthal Hygiens is marked other than "ratural", or items 23a or 28a-1 show sumatic event, it a Marilcal Examination must be coulded at	by Funeral Directo	11. Marital Status 1 Never Married 2 A Marr 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dai	ces? 2. St No		Was Decedent If Yes, specify of 1 ☐ Yes 2 ☑			ecify Yes or No- Rican, etc.)	Blac	Americk, White,		
215-0	be filed within 72 hours after ital Hygiene. Id other than "natural", or Ite svent, the Medical Examina	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-	4or 5+)	(Give	dent's Usual Od kind of work do DO NOT use re	one during mo tired)	ost of work	ing	16b. Kind of Bu		dustry	
Maryland 21215-0036	d be filed wintal Hygier of other the	Be	10 17. Father's Name (First, Middle, Andrew Ritter			nous	sekeepi	18. Mot	_	e (First, Middle, I				
Mary	es 1 and 2 should be for Health and Mental I firm 27 is marked or rother treumatic sve	2	19a. Informant's Name/Relations! Cathy Koontz –							al Route Number			,	
altimore,	Peges 1 ar nent of Hea int: if itsm: iry or other		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from S	tate	Place of Dispo cemetery, crer	sition (Name on matory or other wn Mem.	f place)		Date	20c. Location -	City or To		I
Baltii	permit. Peges Department of the important: if its eny injury or of once.		21. Signature of Funeral Service		Min.		2. Nome and A	dress of Fac	ility M	IINNICH I	FUNERAL	HOM	Ξ.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. ENd	used the dear ch line.	lan	er the mode of		s cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
8760,	certificate be executed vding physicien and use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	r as a consec								999-10	
O. Box 687	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of c	al death 3	Ectopic pregn.				23d. Date Mor		ery Day Year	
rds, P.	requires that the de neen signed by the a hould be detached t	۵	Part II. Other significant condition	ns contributing to dea	ath but not res	sulting in the u	nderlying cause	given in Par	ı I.				ne cause of death?	
	The law ete has b page 2 s	Completed								24a. Was a autops perform	ned27 ∣ d	Vere autorior to colleath?	psy findings availa mpletion of cause of	ble of
Vital	Physicien: Th this certificete ral director, pag	Be	25. Was case referred medical examiner?	Hospital:				Other		n (Check only on	e e			
	After After	tion: To	1 Yes 2 PNo 27. Many r of Death 1 V Natural 5 Pendin 2 Accident investig	28a. Oate of (Month		28b. Time of Injury	28c.	njury at Work? 1 □ Yes 2 [me 5 seside 28d. Describe ho			y)	
Division	al or Attending s after death. It Director: After Id in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	28e. Place o	of Injury - At h g, etc. (Specia	ome, farm, str fy)	eet, factory, off			28f. Location (St City or Town		er or Rura	il Route Number,	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (29a. Certifier 1 Certifyin (Check only one)	g Physician: To the b Examiner: On the bas and manne	sis of examina	owledge, death	n occurred at the	e time, date a	and place, eath occurr	and due to the cared at the time, d	ause(s) and mar ate and place, a	nner as s ind due to	tated. o the cause(s)	
	To the within To the Comp	ž	29b. Signature and title of certified	3 12 au	non	in HI	29c Lic	ense numbe	37	> \	9d. Date signed	(Month,	Day, Year)	
7	H-5		30. Name and address of person	who completed cause	of death (Iter	m 29a) (Type,	Print)	Ylali	016	MIERNE	11-10	ron	Jan M	1
	Sta Registr		31. Date filed (Month Day, Year)	2007 32 2	gistrar's Signa	ature	, , , , , , , , , , , , , , , , , , ,	, raid	p+1 V	11 Just L	My IV	YC.3	2174	2

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Thomas Anthony St. John, July 2007 11:50 A 14. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Director New York 11-16-1929 212-26-5861 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Events. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 □ No Funeral Director MD Chesapeake Beach Calvert. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7715 Old Bayside Road 20732 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates:1948-50 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: à Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Amusement Park Superintendant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Kaminskis Clarence Earl St. John P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 857, Chesapeake Beach, MD 20732 Marie E. St. John, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Karcremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7-19-07 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepatocellular Carcinoma Immediate Cause (Final Primary Physician disease or condition resulting in death) /Medical Due to (or as a consumence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner alor Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral C Hospital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier D17245 15,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

19 E. Gerald P. Sterner, Ches. Beach Rd., Owings, MD 20736 M.D., 31. Date filed (Month, Day, Year) 32. Registry's Signature

State Registrar

DHMH 17 Rev 1/2001

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Registrar

State

PMSP

Kuy, Crofton.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PrPZ

2007

31. Date filed (Month, Day,

2225

32. Registrar's Signature

State

Registrar

DHMH 17 Rev 1/2001

Joanna M. Peloquin, M.D. 600 North Wolfe Street, Baltimore, Maryland 21287

RES-000

7/13/07

Joanna M. Peloquin, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18

2007

32. Registra/s Signature

31. Date filed (Month, Day, Year)

Ammend # 1&4a per M.E. office, DLB, St. Mary's Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05441 State of Maryland / Department of Health and Mental Hygiene Jonathon Robert Senn Certificate of Death 1- For State Reg. No. Time of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 16, 2007 0018 hrs Medical Examiner Jonathan Robert Senn 4c. County of Death 4a. 14 Heme (if not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's Callaway If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours Country)Virginia 04/08/1989 Director 1 X M 2 F Yrs 18 248-85-6735 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 1 Yes 2 X No ms 23a or 28a-f show be notified at once. Maryland St. Mary's Callaway death with the Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 20620 45112 Hewitt Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: White 9 1 Yes 2 X No specify: If Yes, Give Year Divorced 3 Widowed Examiner 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 hours bent of Health and Mental Hygiene. Completed Elementary/Secondary (0-12) College (1-4 or 5+) than item 27 is marked other than 'traumatic event, the Medical 21215-0036 Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorraine Snyder Be Anthony J. Senn (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ည 30 South Horseshew Drive, Milford, DE 19963 9 Anthony J. Senn/ Father 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Removal from State 1 X Burial 2 Cremation 3 Charles Memorial Gard 07/20/2007 Leonardtown, Maryland Important: injury or otl Donation 5 Other Specify 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Funeral Serviçe e e Brinsfield Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death 'Medical a. Contact shotgun Wound of Head and Neck Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit 4a per me g870 8-1-07 vt sician/Medical X AMENDED g physician a the burial -UNPENDED the Hospital or Attending Physician: The law requires that the death certificate be 23d, Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth use as t past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte be detached for u 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 V No 3 Probably 4 Unknown ρ σ. 24b. Were autopsy findings available Completed 24a Was an Division of Vital Records, prior to completion of cause of autopsy death? performed? has Nο 1 V Yes No ✓ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ Residence 6 Other: Scene Hospital: Nursing Home 5 DOA ER/Outpatient 3 Inpatient 2 this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death Subject shot self Certification: FOUND: Yes 2 V No Natural 5 Pending death. Director: 0012 hrs Jul 16, 2007 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 45112 Hewitt Road, Callaway , MD 3 V Suicide determined (Specify) Single Family Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

To the Funeral

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day Year 3

30. Name and address of person who completed cause of death (Item(23a)

and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

July 16, 2007

29c. License number

O.C.M.E.

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | | | | | State
Registrar per DR/wichd/07-30-07/dls Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** AM Beverly Young Tipton 12 2007 July 4:44 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 28860 Hudson Corner Rd. Somerset Marion If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 219–50 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F Yrs. Director 73 Feb 10, 1934 Wash, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I ahow or than "natural", or items 23a or 28a-f ahore the Medical Examiner must be notilized at Y☐Yes 2☐No Directo MD Somerset Marion 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28860 Hudson Corner Rd. 21838 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Professional Federal Government treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clyde W. Young Jacqueline Webb 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Item 27 Jacqueline Tipton/daughter 28860 Hudson Corner Rd., Marion, MD 21838 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury or permit. Page Department of Important: If any Injury or Crematory of 7/13/2007 Delmar, DE ' 4 ☐ Donation 5 ☐ Other (Specify) Delmarva 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebro **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tensiun 1 Yes 2 Probably 4 Unknown as been sign 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 1 Yes 1 Yes 2 1 NO Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 (3) Nesidence 6 Other (Specify) 1 Yes 2 No 은 After this of 2 EP/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manney of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 Medical 29d. Date, signed (Month, Day, Year) 29b. Signature and 29c. License number who completed cause of death (Item 23a) (Type, Print)

10 401 0 LD GEONGETOWN XD 30. Name and address of perso # GOOZH MD IDEL

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

1 8 2007

			For State Registrar	Sta	ate of M	1arylan	-	artmen <i>tificat</i>			and M	ental Hyg	jiene leg. No.		24698
×	Physicia		Decedent's Name (First, Middle Jacob	B.		Terre	11 .	Jr.				2. Date of Dea Month July 1		07 Yea	3. Time of Death 1:00 P M
-	/Medic Examin		4a. Facility Name (If not institution, Ft. Washington H	•		r)		, ,	Town, or Vashir	Location o	of Death			County of De ince Ge	
-	Funeral Director		_	6. Sex	7. /	Age (In yrs. 1	ast birthday) Yrs.		1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	933311)		Birthplace (State or Foreign Country) Shington, DC
	<i>h</i>		Usual Residence of Decedent 10a. State 10b. County			10c. City	y, Town or Lo	cation							10d. Inside City Limits
	the Mary 28a-f sh nutified	rector	Maryland Prince 10e. Street and Number	George'	S	Ft	. Washii	ngton 10f. Zip	Code				10g. Citiz	en of What	1 Tyes 201No Country?
	sath with s 23s or rust be	Funeral Director	507 Kisconko Turn	1	na Dagada	nt Ever in U.	e 13 '	Was Dece	20744		igin? (Sne	ecify Yes or No-	1	US 4. Race - A	A merican Indian,
036	ours after de al', or Item Examiner	वि	11. Marital Status 1 Never Married AMArri 3 Widowed 4 Divorced	ed 1	as Deceder med Force Yes 24 Yes, Give ear or Dates	s? No		If Yes, spe				ecify Yes or No- Rican, etc.)		Black, W Specify:	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, I.e. Medical Examinar must be nutified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	t grade com	pleted) ollege (1-4d	or 5+)	16a. Dece (Give life. Circul	kind of wo DO NOT u	rk done d se retired	during mos ()	st of worki	ng		od of Busine Vashing	ss/Industry ton Post
land 2	ild be filled lental Hygi ked other ic event, i	To Be Co	17. Father's Name (First, Middle, Jacob B. Terrel	Last) 1 Sr.							er's Name rtheni	e (First, Middle, a Johr		Su <i>mame)</i>	
Mary	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relations Gwendolyn Terrell	hip <i>(Type, P</i> / Wife	rint)							al Route Numbe Shington,			
Baltimore,	Pages 1 a ent of Hez nt: If Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		al from Sta	_ 0	Place of Dispo cemetery, cre SUTTECTI	on Cen	etery netery	7	07/19,	50	Cli	inton, l	or Town, State Maryland
Balti	permit. Departm Importal any Inju		21. Signatur Funeral Service									rge P. Ka on Hill, N			Hame IA 0745
±	Physician		23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complication only one car	use on each	sed the deat				_		or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	(a		as a conseq		\ \ \ ~	~~	0,					
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S, D	uires that the death signed by the atte d be detached for		Part II. Other significant condition	ons contribu	ting to deat	h but not res	sulting in the u	underlying	cause giv	en in Part	l.	23e. Did to	_		e to the cause of death? Probably 4 Unknown
Vital Record	yaician: The law requir is certificate has been si director, page 2 should	Completed										24a. Was autop perfo		prior	e autopsy findings available to completion of cause of h? Yes 2 \sumbder No
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on of \	ਜ਼ ਦੁਾਰ	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28 ng	a. Date of l (Month,		ER/Outpatie 28b. Time o Injury		28c. Injur Wor	4 🗀 14		ome 5 Residence 1			Specify)
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R	(2)		30. Name and address of person Barry Re						#201	l Temo	le Hi	Us, Mary	land	20748	
	St Regist	ate trar	31. Date filed (Month, Day, Year, JUL 1, 8 20	07			ature pour					,)			

State of Maryland / Department of Health and Mental Hydres 24.6.00 of Death 24.6.00 o	amend line aaco hlth d	19a apt	per fd & line 29d per r 7/17/07 dlw Please	lype or Print in Blac	k Indelible Ink	. Ensure A	Il Copies	Are Legible.	
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190 Mailing Address (Street and Number of Ranal Route Number). City or Town, State Zo Cose)	e file other	3e C	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
Physician (Medical Examiner) 23a Part I. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest eleven shock, or hear failure. List only one cause on each line. 23b Part I. Enter the deases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Interest eleven shock, or hear failure. List only one cause on each line. 25c Place of Death (These or Rural Floride Number of Caylor) and the part of the cause of death? 27c Place of Death (These or Rural Floride Number of Rural Floride Number	Val Duid b Ment Ment Ment Ment Ment	To				Stella	Parr		
Physician (Medical Examiner) 23a Part I. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest eleven shock, or hear failure. List only one cause on each line. 23b Part I. Enter the deases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Interest eleven shock, or hear failure. List only one cause on each line. 25c Place of Death (These or Rural Floride Number of Caylor) and the part of the cause of death? 27c Place of Death (These or Rural Floride Number of Rural Floride Number	Mar ind 2 sho alth and 27 ls m		19a. Informant's Name/Relationship (T) Teresa Evans/Daug	Teresa Evans 19th					
Physician (Medical Examiner) 23a Part I. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interest eleven shock, or hear failure. List only one cause on each line. 23b Part I. Enter the deases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Interest eleven shock, or hear failure. List only one cause on each line. 25c Place of Death (These or Rural Floride Number of Caylor) and the part of the cause of death? 27c Place of Death (These or Rural Floride Number of Rural Floride Number	ages 1 and of He int of He int		1 ☐ Burial 2 🖾 Cremation 3 ☐ I	Removal from State	ry, crematory or other pla	ce)			
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Comparison of the property of the pr		ÜΠ.		Due to (or as a consequence	of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Comparison of the property of the pr	587 licate phys	dic		d					
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29a. Certifier Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07/12/07	ivision or Attendition of Attendent death	rtifical	3 Suicide 6 Could not be	28e. Place of Injury - At home, fabuilding, etc. (Specify)		163 2 110			Rural Route Number,
one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 07/12/07	Hospitel A hours e Tuneral [(Check only 2) Medical Exam	ner: On the basis of examination ar	e, death occurred at the til	me, date and place,	and due to the	cause(s) and manner a	as stated.
290. Signature and filled of german 290. Elease monthly 290. Date signed (monthly, Day, Year) 07/12/07	the hin 24	Med	one)	and manner stated.					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	100	1	30. Name and odress of person who c	ompleted cause of death (Item 23a)	(Type, Print)	PANSH	Giffiani	Millan	ONLEANO
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 31/08	St Regis		31. Date filed (Month, Day, Year) JUL 17	32. Registrar's Signature	K Since !	, , , , , , , , , , , , , , , , , , , ,	-11 10119	11 ore.	21108

			for State Registrar		State of M	arylar	-			ealth a	and M	ental Hy	gien		2	1.71	00
	3,3	ø	1. Decedent's Name (First	Middle, Las	")							2. Date of De	aath Da	ay Yea		3. Time of I	Death
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2	Examir		4a. Facility Name (If not in	stitution, give	street and number))		4b. City	Town, or	Location o	f Death		40	. County of D	eath		
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	Funeral		5. Social Security Number	6. Se		ge (În yrs.	last birthday)	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bit (Month, Da	th av. Year	9. 8	Birthplac Country	e (State or	Foreign
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ita	Physician: r this certific ral director,	Be	25. Was case referred to rexaminer?	-	2-02-02-			- 7.00		26. Place	of Death	Check only	one				
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2	ng P fter t nera		27. Manner of Death 1 ■ Natural 5 □	Pending	28a. Date of Inju (Month, Da	ıry ıy Year)	28b. Time of Injury	1	28c. Injury Work			8d. Describe					
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Division of Vital	i or Atten after deat Director: I in by the	ij	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injuding, et	ury - At h	ome, larm, stre	et, factor	y, office		2	8f. Location (City or To		nd Number or	Rural R	oute Numb	er,
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	hou hou uner		29a. Certifier 1 X C	ertifying Phy	sician: To the best	of my kno	wledge, death	occurred	at the tim	e, date and	place, a	nd due to the	cause(s) and manner	as state	ed.	
	- 'V - 0	edicai	one)		ner: On the basis of and manner st	ated.		saugation	i, in my up	minori, deall	. occurre	u at the time,	date an	u piace, and c	ina in iu	e cause(s)	
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	W,		30. Name and address of	erson who c	ompleted cause of c	death (Iten	n 23a) (Type, P	rint)	, ,			41		25/			
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	1	For State Registrar			,	Cei	rtificate	e of L	Death		R	eg. No.			
	_	Decedent's Name (First, I	fiddle, La	ist)							2. Date of Dea Month	th Day	Year		of Death
Physician /Medical		Bernadette	Mary	Webb								18	2007	12:	50 P
Examine	_	la. Facility Name (If not insti)		4b. City,	Town, or	Location	of Death		4c.	County of De	ath	
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Funeral		5. Social Security Number	6. 9		ge (In yrs. la		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 6/26/1	Year)	9. Bi	rthplace (State	
Director	-	219-30-5848		1 L M 281F	73	Yrs.					6/26/1	934		MD	
3	-	Usual Residence of Decede			10c. City.	Town or Lo	cation							10d. Inside	City Lim
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ns 23	23 L	11. Marital Status		12. Was Deceden	t Ever in U.S	. 13.	Was Deced	dent of H	ispanic Or	igin? (Spec	cify Yes or No- lican, etc.)	1		erican Indian,	
in the	2	1 Never Married 2	Married	Armed Forces 1 ☐ Yes 2X							(ican, etc.)		Bfack, Wh		
S 2	2	3 ☐Widowed 4 ☐ Dive	rced	If Yes, Give Year or Dates:	:		1 🗌 Yes	2L 4N 0	Ѕреспу.				Specify: WI	irre	
real real	Completed	15. Dec	edent's E	ducation ade completed)		16a. Dece	dent's Usua	al Occup	ation	st of workin	a	16b. Kir	nd of Busines	s/Industry	
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raumatic event, III	E C	17. Father's Name (First, Mi									(First, Middle, s W. Wa				
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if item 27 is marked other than "natural", or items 23e or 28e-1 show or other traumatic event, the Madical Examinar must be notified at or other traumatic event, the Madical Examinar must be notified at	1	19a. Informant's Name/Rela						•			Route Number Ocean C				
m 27 her tr	4	Nancy Ausmu	is MC		20h Pla	ace of Dispo			JOWII		ate			or Town, State	
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important: If any injury or once.	-	4 Donation 5 Oth			St.	Stan				7/23/	2007 e Burba				
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2 sh	Completed by Physician/	(ungesti)	ie H	eart Failu	re						24a. Was autop	sv	prior t	autopsy finding completion o	gs availa
within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	E O										perfor 1 ☐ Yes	med? 2,⊠ No	death		
s certificate has blirector, page 2 s	Be	25. Was case referred to mexaminer?	edical					-		e of Death	(Check only o	ne)			
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DIE		30. Name and address of p	. 1	d completed cause of	f death (Item	23a) (Type	Print)	1 0	772	11-116	ING Priv	10 1	P. 1.	Mnnis	. / 1
A15		31. Date filed (Month, Day,	Jala Voor)	DO ATLANT	strar's Signal	Mers!	Hay noto	1 ((0)	ncaltr	ives priv	C 1	Derlin,	1017 710	7.1
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DHMH 17 Rev 1/2001

DOB: 6/26/34

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7 200^{Year} 2:09 P M Robert Lee Walker, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Worcester Mill Rd. Berlin If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1 ☑ M 2 ☐ F 214-80-5192 7/20/1961 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 TXNo Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21811 USA 1 Mill Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 X No 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lee Walker, Sr. Dolores Unger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Mill Rd., Berlin, MD 21811 Terry Walker / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Evergreen Cemetery 7/20/2007 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 ma 23a. Part1. Enter the diseas shock, or heart failure. sease, proomplications that call led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lure. List only one cause in (siline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

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Examiner attending physician Physician/Medical for signed by the a d be detached f þ page 2 should Completed peen certificate Be

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p Certification: To

1 LiYes 2 ₩ 9 LiUnknown		9□Unknown		Specify)			
Part II. Other signif	ficant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.		tobacco us	se contribute to the cause of death? No 3 Probably 4 Unknown
					24a. Was auto perf 1 Yes	opsy ormed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case refer examiner?	red to medical			26. Place of D	Death (Check only	one)	
1 Yes 2	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	DOA Other: 4 Nursing	g Home 5 Res	idence 6	□Other (Specify)
27. Man or of Deat 1 V Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred
3 Suicide 4 ⊞Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, fact	ory, office	28f. Location (City or To	(Street and own, State)	l Number or Rural Route Number,
29a. Certifier (Check only one)		ysician: To the best of my kno niner: On the basis of examina and manner stated.					and manner as stated. place, and due to the cause(s)
29b. Signature and	title of certifier	. A	2	29c. License number		29d. Date	e signjed (Month, Day, Year)

BA 3

State

Medical

Registrar

Division or Vital Records, P.O. Box 68760 or Attending Hospital

Physician /Medical Examiner **Funeral** Director with the Maryland Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other trainment. **Physician** /Medical Examiner ed by the attending physician detached for use as the buria within 24 hours after death To the Funeral Director: 1 📙 🖙 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P18019 18,2000 13ME 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) MD 21747 MILL ST MAGERSTOWN SH-10+1 DATTHE 340 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 0 2007 Registrar

		For	Se Type or Pri State of M	laryland / Dep		Health and I	Mental Hyg	iene	ile.
	_	1 - State Registrar		Ce	rtilicate of	Deam		eg. No.	7 24 / 114
Physic /Medi		Decedent's Name (First, Middle,	,				2. Date of Dea Month July	Day	3. Time of Death 2:45 P
Exami		4a. Facility Name (If not institution,	give street and number)	4b. City, Town, o	or Location of Death	1	4c. County o	
		Calvert Memoria	al Hospital		Prince	Frederic	k	Calve	ert County
Funeral			6. Sex 7. A	ge (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
Director		579-14-3530	1 X M 2□ F	87 Yrs.			June 3.		Washington, DC
P.		Usual Residence of Decedent		10c. City, Town or L	onation				10d. Inside City Limits
arylar show d at	_	10a. State 10b. County		Toc. City, Town of L	ocation				1 ☐ Yes 2 X No
e Ma	cto	MD Calver	t County	Owings					
if the or 24	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?
th w 23a ust b	by Funeral Director	1649 Cannery Ro	oad		20736	3		U.S.A	
dea	ne	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13	. Was Decedent of I	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc.
after or it	F	1 ☐ Never Married 2 X Marri	ed 1 XYes 2 If Yes, Give] No	1 ☐ Yes 2 ☑ No		,	Specify:	White
Ours ours Fxa	db	3 ☐ Widowed 4 ☐ Divorced	Year or Dates					Specify.	MILLOG
72 h	etec	15. Decedent (Specify only highes	s Education t grade completed)	16a. Dec	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of wor	king	16b. Kind of Bus	iness/Industry
Ren " Me	ldu	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	ed)			
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	11		Supe	erintender		(= 1		tion Company
be fill tal H H d out	Be	17. Father's Name (First, Middle, I	Last)				ne (First, Middle,		9)
Maryland 21215-0036 nd 2 should be filed within 72 hours aff lith and Mental Hygiene. If is marked other than "natural," or traumatic event, the Medical Exami	2	Warner Wright				1	V. Meca		
2 sho and and is m sum		19a. Informant's Name/Relationsh	ip (Type. Print)	19b. Mai	ling Address (Street	t and Number or Ru	ıral Route Numbe	r, City or Town, S	State, Zip Code)
and and ealth n 27		Evelyn Wright	(Wife)	1649	2 Cannery	Road, Ow	ings, Ma	ryland 2	20736
es 1 of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 DRemoval from State	20b. Place of Disp cemetery, cri	oosition (Name of ematory or other pla	July	12,	20c. Location - 0	City or Town, State
Pag Pag nent ant: I		4 □ Donation 5 □ Other (Sp		🖊 Maryland	1 Vets. Co		1		nam, Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fundat September	icepeee						Calvert, P.A.
a a a a a a a		Michael W.	I de	3	3125 South	hern Mary	land Blv	d., Owin	ngs, MD 20736
Physician /Medical	ı	23a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death)	a HYD	DXK RG	nter the mode of dy		Or respiratory are	rest,	Approximate Interval Between Onset and Death
Examiner				s a consequence of):	0,00	, , , , ,	1.1010 1	0	
	<u>.</u>	Sequentially list conditions,	b. BILL	TERAL s a consequence of):	DIEOKI	AL GFA	05100	7	
ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				1001)	LX(112		
'60, be executed sician and burial-transit	xan	that initiated events resulting in death) Last		S a consequence of):	COUL				
60, be ex ician a				LAUTRITO	(4)	O FAIL	DC TO	778 11C	
687 tificate ig physi as the l	di		20 D	HIGH G	RADE	SNOPIL P	MWSI.	OBSRUC	bod
I Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending physisage 2 should be detached for use as the I	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	ne pf pregnancy 2 Fetal death 3	□Ectopic pregnand □ Other (specify)	ETTE SP	OBSRU	2001.	of delivery
O he d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	at time of death 3					
P.O. that the ded by the detached	F	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
Vital Records, F sician: The law requires that certificate has been signed rector, page 2 should be det	þ	CORON	20 PG	TODUT	224 22a	an	1 □ Y	es 22 No	3 Probably 4 □Unknow
cord: w require been sig	Completed	200	,	THE T	0.0			1	
Reclaw has the great state of the state of t	d d	- ANCIPO	PRKII	LAUDUS	An	>	24a. Was a autop perfor	sy 24b. W	ere autopsy findings available for to completion of cause of
	ပ္ပိ	Co:	· Q7					2 10 1	eath? □ Yes 2 □ No
or Vital Re Physician: The rthis certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hit-t		100		ath (Check only or	ne)	
Or Physical this call dire	2	1 Yes 2 No	Hospital: 12 Impa		BIIL SELDON		lome 5 ☐ Resid		
T g u	ü	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of In (Month, E	njury 28b. Time Da <i>y Year)</i> Injury	Wo		28d. Describe h	ow injury occurre	ed
Division or a or attending Physafter death. Director: After this in by the funeral di	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation]Yes 2 □No			
or Att	Ĭij.	4 Homicide determi	Zoe. Flace of I	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office	•	28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural Route Number,
Ital c	S								
Divisio To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		g Physician: To the bes Examiner: On the basis and manners	of examination and/or					
orthin orthin ompl	Me	29b. Signature and title of certifier			29c. Licen	se number	- 2	29d. Date signed	(Month, Day, Year)
F S F O		1 INTO COLO	100		Trans	61.01-1		0710	4010
7		30. Name and address of person	who completed cause of	death (Item 23a) (Type		164961	•	3110	1
10+1		DR WASSEMP D				d pri	NCE FRE	DC DIVIL	MD 20678
	tate	31. Date filed (Month, Day, Year)	OO Danie	August Cinn obuse		1.00	10 C 1 1-6	DIFICE	7500,13
Regis		E8610	1 1 2007	Balue A	Mark	Ð			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Clarence Leo Young, Sr. /Medical July 2007 11:01 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayside Care Center Lexington Park St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑** M 2□ F 218-14-3515 Director 86 04/23/1921 Maryland Usual Residence of Decedent the Maryland 10b. County or 28a-f show a notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or? 21412 Great Mills Road 20653 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 ☑ Widowed 4 ☐ Divorced ear or Dates **Black** the Medicai 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture Item 27 is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Woodley Young Susan A. Bowman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lillian Jenifer/ Daughter P.O. Box 176, Cheltenham, Maryland 20623 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Queen of Peace Cem. 07/23/2007 | Helen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home P.A. Edward Mc Brins reld, Jr. M00054 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician**) LL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-tran and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Yes 24a. Was an has autops, performed? 25. Was case referred to medical 26. Place of Death Check onl one Other: 1 🗌 Yes 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 4 ☐ Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at C Work? 28d. Describe how injury occurred Injury matural 5 Pending

P.O. Box 68760, Division or Vital Records.

3+10

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed After Director: filled in by within 24 hours a To the Funeral I

2☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and nanner stated. (Check only one) 29b. Signature and title of cortifle 29d. Date signed (Month, Day, Year) 30. Name and address of person who co Neted cause of death (Item 23a) (Type, Print) James C. Boyd, M.D., 41860 Miss Bessie Drive, Leonardtown, Maryland 20650

ORIGINAL

State Registrar

Medical

31. Date filed (Month, Day, Year)

JUL 2 3 2007

32. Begistrar's Signature

Area

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ďŢ 5-00 Kelvin Ordway Alark 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore N/A Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 14, 1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min. 1⊠M 2□F 72 Maryland 213-30-4490 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Gwynn Oak Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 3675 Forest Hill Road **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc 1XYes 2□No 1951 If Yes, Give Year or Dates: 1957 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: American Indian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loreda Garnett Ordway Alark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sondra Alark, Wife 3675 Forest Hill Road Gwynn Oak, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory Inc. 08/02/07 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland ²² Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, N 21. Signature of Funeral Service Licenses 1.01 6-Todd Dring Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or packetine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a nsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an ormed? Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

Department o Important: If any Injury or

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

ို

Funeral

Director

: if Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite

Maryland

death with the Maryland

the burial-transit death certificate be as 1 nse jo signed by the page 2 After this certification funeral director, I

Division or Vital Records, P.O. Box 68760,

or Attending

To the Hospital

death.

Examiner Physician/Medical Completed by Be Medical Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the f

25.			to medical
	examiner?		
	1 🗌 Yes	No No	

5 ☐ Pending investigation

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

3 Suicide

4 ☐ Hornicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Saltinure MP21201

08-01-07

Registrar

3 Dave filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Begistrar's Signature

			1 - State State Registrer	of Maryland / Depa	artment of Health a		6001	24707		
			Decedent's Name (First, Middle, Last)	· · · · · ·		2. Date of Death		3. Time of Death		
	Physici		LORAINE ANT	Al		Month July 3	Day Year	10:35 PM		
	/Medic Examir		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location		4c. County of Dear			
4	CXAIIII	iei	HARBOR HOSPITAL		BALTIMOR		N/A			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under		9. Biri	thplace (State or Foreign		
	Funeral Director		217-46-4352 1 M 2X)		Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye) May 19, 1	1947 Ma	ryland		
			Usual Residence of Decedent			11629 239 3	13-17	Lyrana		
	/land		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits		
	Mar February	ō	Maryland Anne Arundel	Broo	klyn Park			1 ☐ Yes 2 No		
	1 the	rec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry?		
	3a o	by Funeral Director	739 Old Riverside Roa	d	21225		USA			
	ns 2	era	11 Marital Status 12 Was D			igin? (Specify Yes or No-	14. Race - Ame	erican Indian,		
	fter of the r	F	Armed	Forces? I	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	n, Puerto Rican, etc.)	Black, Whit			
33	al', ol	by	If Yes,	Give or Dates:	1 ☐ Yes 🎉 No Specify:	:	Specify: W	hite		
21215-0036	2 hou	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupation	161	b. Kind of Business	/Industry		
7.	in 7	ple	(Specify only highest grade complete	life.	kind of work done during mos DO NOT use retired)	st of working		·		
7	iene iene	E	Elementary/Secondary (0-12) Colleg	e (1-4or 5+) Bu	s Driver		School	S		
D	Hyg othe ent,	BeC	17. Father's Name (First, Middle, Last)			er's Name (First, Middle, Mai	iden Sumame)			
lan	ld be enta ked ic ev	To B	John Gould			Avis Lewis				
2	and M		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number	er or Rural Route Number, C	ity or Town, State, 2	Zip Code)		
Ž	od 2 lith a 27 lg		Patsy Carole Lanning, D	aughter 12638	Greensboro Ro	nad Greensboro	n Marvla	nd 21639		
ō,	Hea Hea tam othe		20a. Method of Disposition		sition (Name of matory or other place)		. Location - City or			
2	ages nt of t: # i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	JIII State	matory Inc.	08/01/07 Ba	oltimore	Maryland		
Baltimore,	artme artme ortan njuri		21. Signature of Funeral Service Licensee		,					
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examination was be redifficed at ODGs.		Momory Dry	-	Name and Address of Facility Cremation Soci 299 Frederick	iety Of Maryla	and, Inc.	and 21220		
			Thomas Gregor () 23a. Part1. Enter the disease, or complications the					Approximate		
			shock, or heart failure. List only one cause of	on each line.				Interval Between Onset and Death		
	Pnysician		disease or condition resulting in death) a. INTRA CEREBRAL HEMORRHAGE 10							
	/Medical Examiner		Due	to (or as a consequence of):	-)					
		_	Sequentially list conditions, b.	14 PERTENSID	N			UNKNOWN		
	ad sit	Examiner	cause. Enter Underlying	to (or as a sunsequence of): ROKE						
	and tran	сап				CHCHONN				
60,	cian cian buria			to (or as a consequence of):				· · · · · · · · · · · · · · · · · · ·		
8760,	cate be executed physician and the burial-transit	dlcal	d	ABETES				UNKNOWN		
Bay≽€	ding page as	0	IF FEMALE:				7			
B	ath c	ian	in the past 12 months?		Ectopic pregnancy		23d. Date of del Month	ivery Day Year		
	that the death certifi ed by the attending I detached for use as	Physician/M	1 Type 2 700	egnant at time of death 5 [Other (specify)			-		
P.O.	d by	P _h		a danth hut ant manulting in the co	adadina as as as as as is Dad I	220 Did tabas	an una anntributa ta	the cause of death?		
ď,	e de	by	Part II. Other significant conditions contributing to HYPER UPIDEM	-	idenying cause given in Part i	1 □ Yes		obably 4 Unknown		
oro	w require	ted					SPS 140 2 1 1	obably 4 Donkhown		
Records,	has by	Completed	STOMACH CANC	EYZ		24a. Was an autopsy	prior to	topsy findings available completion of cause of		
_	The ate h page	NO.				performed	death?	2□ No		
Vital	Physician: this certificaral director, I	Be (25. Was case referred to medical examiner?		26. Place	e of Death (Check only one)	- 1			
of V	nysic lis ce dire	10		☐Inpatient 2☐ER/Outpatien	t 3 DOA Other: 4 Nu	ursing Home 5 - Residence	e 6 □Other (Spe	cify)		
			27. Manner of Death 28a. Da 1√Natural 5 ☐ Pending (M.	ate of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how i	injury occurred			
ō	tandir feath. tor: Al	atlc	2 Accident investigation							
Division	I or Attandi after death. Diractor: A i in by the fu	ξij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined bu	ace of Injury - At home, farm, str ilding, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S		ıral Route Number,		
Ö	s after single and pingle and in	Certification:		manigration (appears)			,			
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, death e basis of examination and/or in-	occurred at the time, date an	nd place, and due to the cause	e(s) and manner as	stated.		
	n 24 ha F	Medical		e basis of examination and/or inv	restigation, in my opinion, dea	ath occurred at the time, date	and place, and due	to the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Monta	h, Day, Year)		
	,		Ruth Indahyun	a, MD.	RES 001	D I	ULY 31	2007		
/	/		30. Name and address of person who completed c		Print)			<u>'</u>		
(P		3001 S. HANDVER S	ST, BALTIN	NORE, MD	24225				
	, Sta	ite		. Registrar's Signature						
	Registr	ar	AUG 0 2 2007	Sur St. Som	Les of the second					

		í	For State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of F			iene	17	24708
	0 4		Decedent's Name (First, Middle, La.	st)				2. Date of Death		Year	3. Time of Death
	Physici /Medic		Victor C. Albrec	ht				July 21	, 2007		11:00 PM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o		ath	4c. County		
			Kensington Nursi			Kensi			Mont		
	Funeral		5. Social Security Number 6. S	ex 7.A ☑M 2□F	ge (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		^{Year)} 1924	Cour	place (State or Foreign ntry) Jersey
	Director		127-28-8717 Usual Residence of Decedent		0.5			Julie 0,	1924	New	Jersey
	yland	Ì	10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Marish	ctor	MD Montgom	ery	Silve	r Spring					1 □ Yes 2√ No
	or 28	Oire	10e. Street and Number	A JL	100	10f. Zip Code	0010	10	Og. Citizen of W		ntry?
	ath w	Funeral Director	10000 Brunswick	· · · · · · · · · · · · · · · · · · ·			0910	10 11 11	USA		and Indian
	er de Items	inne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces	REVER IN U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		k, White,	can Indian, etc.
36	urs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	TZ = == ===	1 ☐ Yes 2 🎇 No	Specify:		Specify:	whi	te
Š	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Madical Ever's er timel be traitified at	ted	15. Decedeni's E	ducation		dent's Usual Occup		nekina	16b. Kind of Bu	siness/In	dustry
2	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retired	d)	Urking			
7	ed wi	Son	12	4	infa	entry off		(C.) 101-01	U.S.		•
and	be fill hta! H ad otl	Be	17. Father's Name (First, Middle, Last, Victor Albrecht					ame (First, Middle, A	naiden Sumami	э)	
$\frac{3}{2}$	12 should be filed within h and Mental Hygiene. 7 is marked other than " reumatic avant, It e Men	2	19a. Informant's Name/Relationship (19h Maili	nn Address /Street		e1 Metz Rural Route Number,	City or Town	State. Zir.	Code)
and 2 s	d 2 s Ith an 27 is		Charles Albrecht/			Box 350			o., o. , o,		,
ē,	t Heal Hem tem other		20a. Method of Disposition	5011	20b. Place of Dispo	sition (Name of			20c. Location -	City or To	own, Slate
9	Pages nent of I int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 🛣 Other (\$pecit		9	matory or other plac					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant. The Profest Evant is erroral to a rolling an Once.		21. Signature Euneral Service Licer Ronald S	1_	ector St			d 655 W.	Baltimo	re S	treet
			234. Part . Enter the disease, or com	plications that cause	ed the death. Do not ent	1timore, er the mode of dyir			est,		Approximate Interval Between
	Physician		shock or heart failure. List only Immediate cause (Final	one cause on each	101 0 /	icenia					Onset and Death
В	/Medical		disease or condition resulting in death)	a Due to (or a	s a consequence of):						
	Examiner		Cognostially list conditions	b							
_	D =	Iner	Sequentially list conditions, if any, leading to immediate the first line than Cause (Disease or injury		s a consequence of):						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
8760,	The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	a E									
687	ficate phys s the	odic		_ d							
Box (that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		-			23d. Date	e of deliv	ery
	death e atte d for	cla	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant		<pre>JEctopic pregnancy J Other (specify)</pre>	у		Mor	nth	Day Year
P.0.	t the by the	hys	9 🗆 Unknown	9 Unknown							
	res tha igned be del	by P	Part II. Other significant conditions of		but not resulting in the u	nderlying cause giv	en in Part I.				he cause of death?
ord	w require been si should I	ted	77/7					1 ☐ Y€			pably 4 □Unknown
ec	law r	Completed	DM					24a. Was a autops	n 24b. V	Vere auto	ppsy findings available impletion of cause of
<u> </u>	iclan: The lav certificate has rector, page 2	Con						perform		leath?	210 No
Vita	iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		0#	or /	eath (Check only on			
ō	Phys this ral dir	- T	1 Yes 2 No	1 Unpai	tient 2 EP/Outpatier	IT 3L DOA	4 Mursing	Home 5 Reside			(y)
on	ding F h. After funera	tlon	1 Natural 5 Pending 2 Accident investigatio	28a. Date of In (Month, D	ay Year) Injury	Wor	rk?` Yes 2∐No	2031 00001100 110	,,		
Division of Vital Records,	Attending Physician: or death. ector: After this certification by the funeral director.	ifica	3 Suicide 6 Could not b	28e. Place of le	njury - At home, larm, st	reet, factory, office	-	28l. Location (St		er or Run	al Route Number,
á	at or A s after il Direction by	Certification;	4 Homicide	building, e	etc. (Specify)			City or Towr	i, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (it of my knowledge, deat of examination and/or in stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	o par	MD	29c. Licens	se number		9d. Date signed		
}) ende	()	1416	Do	064624	†	July :	23,2	2007
			30. Name and address of person who		death (Item 23a) (Type,	Print)	. 1	t , Kensing		10	2000
			0	HARMA	10901 CI	nnecticat	Hvenu	e, Kensin	gten, 1	10	20373
	Sta Regist		31. Date liled (Month, Day, Year)**	IIIZ	strar's Signature	- N -					
	ricgist	U1	AUG 0 2 2	UU1 Deale	12 13 Mg	CONS.					

Registrar

State

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BALTO MA

21289

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

31. Date filed (Month, Day, Year)

AUG 0

2835

32. Registrar's Signature

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obby Bethea	1.	State of Maryland / Departm - For State Certific	ent of Health and Mental Hygiene cate of Death	Reg. No. 2017 217
Physicia		registrar 1. Decedent's Name (First, Middle,Last)	2. Date of I	Death 3. Time of Death
edical Examin	er	Bobby MeLuin BETHEA 4a. Facility Name (if not institution, give street and number)	July 28 4b. City, Town, or Location of Death	, 2007 2155 hrs
	4	4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	Baltimore	NIB
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	7/	f Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	E	218 67 8157 1XM 2 F 3	Yrs. Morius Days Hours Will Style	430, 2003 Foreign Country) M CA
a Section of the sect		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits
*	<u>_</u> /	maylon N/A BAH	HUNE	Yes 2 No
Maryland 28a-f show d at once.	ecto	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.		3//6 WINDSON AND 11 Marital Status 12. Was Decedent Ever in U.S.	2/2/6 13. Was Decedent of Hispanic Origin? (Specify Yes o	
9036 within 72 hours after death with the Maryland iene. ter than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Yes 2	If Yes, specify Cuban, Mexican, Puerto Rican, etc.	
after de al", or	by F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: Black
hours 'natur Exam		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 tygiene. other than '	Completed		THILD	
Fryg Hyg		17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Mide	
121 Id'be fi Mental narked event,	o Be	Bulby M. BETTER, 19a. Infor nt's Name/Relationship (Ty., Print) 1	9b. Mailing Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code)
AD 2 sho 1 and 27 is mati	+	THELMA RUSS / FOSTER MUTHER -	3/16 WINDSON AUG BAS of Disposition (Name of cemetery, Date	1 hiren, Du 21216
re, N 1 and f Health if item er trau	Î	Crem		
그 집 집 된 님		4 Donation 5 Other Specify:	22. Name and Address of facility MAATIN	1 Luce De Aur, Mory love
Balti permit. Departr Import injury	_	21. Signature of Funeral Service Censee	22. Name and Address of Facility 1977	o BAKARIA, Del 21215
Physician		23a. a l. Enter the disease, or complications that caused the death. Do	not enter the mode of dying, such as cardiac or respirator	y arrest, shock, or heart Approximate Interval Between Onset and
xaminer	4	alure. List only one cause on each line. Immediate Cause (Final disease a. Asthma Attack		Death
,		or condition resulting in death) Due to (or as a consequence of):		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	18 17 1	
	Examiner	Ciscass of injury that initiated events resulting in death) Last Due to (or as a consequence of):		
o, e be executed ysician and burial - transit		d.		
30, te be ex sysician	ledical	IF FEMALE: 23c. If yes, outcome of pregnand	28/07 TT <u>/ #23a,27,perME,g872, 10</u>	0/22/07 TT
Box 6876 e death certificate the attending phy ed for use as the b	Physician/M	23b. Was decedent pregnant in the	2 Fetal death 3 Ectopic pregnancy	Month Day Year
Sox (leath ce attender for use	ysici	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)	- 4
		Part II. Other significant conditions contributing to death but not resul	and in the directlying eases give in	Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown
S, P.(uires that n signed Id be deta	Completed by			Was an 24b. Were autopsy findings available
ords, aw requir as been s	plet			autopsy prior to completion of cause of performed?
tal Rec cian: The l certificate !		OF Managed to modical	26.Place of Death (Check only one)	Yes 2 No 1 Yes 2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. **I Director: After this certificate has been signed by led in by the fumeral director, page 2 should be detached.	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: Inpatient 2 ✓ ER	Other	5 Residence 6 Other:
of \ng Phy	n.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28		cribe how injury occurred
sion ttendi death. ctor: /	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	tion (Street and Number or Rural Route Number, Cit
Divis al or A s after al Dire	Certification:	Suicide 6 Could not be determined (Specify)		own, State)
Hospit Puner: Funer:	al Ce	29a. Certifier 1 Continue Physician: To the best of my knowledge	death occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
Division of Norther Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	one) 2 Medical Examiner: On the basis of examination and/one and manner stated.		29d. Date signed (Month, Day, Year)
	Ž	29b. Signature and title of certifier	29c. License number O.C.M.E.	July 29, 2007
		30. Name and address of person who completed cause of death (Item/23		
		Zabiullah Ali, M.D. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201	
	tatto	31. Date filed (Month, Day, Year) 32. gistrar's Signature	diale	
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					,	Cer	tificate	of	Death			Reg. No.				
			1. Decedent's Name (First, Middle, Le	est)							2. Date of De	eath		11.	3. Time of	Death
	Physici-		Delfone	C. Banks							Month July	2 7	20	'ear () 7	164	4
	/Medic Examin		4a Facility Name (If not institution, gi					T	4b. City, To	wn, or Lo	ocation of Deal		County of		104	
4	LXdillii	CI	TAUDELLIOOD CAD	E CENTED					TIT 12	mon.			PROTE	00		
	Consuel		LAURELWOOD CAR 5. Social Security Number 6.		e (In yrs. la	st birthday)	If Under 1	Year	If Under	TON 24 Hrs.	8. Date of Bi		CECIL		ace (State o	or Foreign
	Funeral Director			1∰M 2□F	3		Months E	Days	Hours	Min.	8. Date of Bi (Month, Di AUG 1	ey, Yeer)		Count	yLAND	-
	V-		Usual Residence of Decedent								AUG I	0 136	00	MAIN	THAND	
	aryland show		10a. State 10b. County		10c. City,	Town or Loc	ation							10	d. Inside C	ity Limits
	Man,	Ö	MARYLAND HARFO	00 00		7\ TO	ERDEEN	T							1 ☐ Yes	2X No
	/ith the Maryla or 28a-f shor	9	10e. Street and Number	KD CO	1	AD	10f. Zip Co					10g. Citi	zen of Wh	at Count	ry?	
	A M		1522 MIMOURIE	C TNI				2	1001				CA			
	a 2	era	1533 MITCHELL:	12. Was Decedent	Ever in U.S	13. W	as Deceden		1001 lispanic Ori	ain? (So	ecify Yes or N		S.A. 14. Raca -	America	n Indian.	
10	Te a	듄	1 XNever Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ X		1					ecify Yes or No Rican, etc.)			White, e		
Maryland 21215-0036	within 72 hours after deeth with the Maryland ane. then "netural", or items 23s or 28s-f show he Medical Examiner must be notified at	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□Yes 202	No	Specify:				Specify:	BLA	CK	
ŏ	tura tura	8	15. Decedent's E			16e. Decede	nt's Usuel C	ocup	ation			16b. Kir	nd of Busin			
15	in 72	Completed	(Specify only highest gr	ede completed)		(Give k	ind of work of O NOT use i	done retired	during mos	t of work	ing	10017111		700077712	2011	
2	filed with Hygiene. ont, the	Ĕ	Elementary/Secondary (0-12) 7th grade	College (1-4or 5	5+)		SABLEI		,				N/A			
0	be filed ntal Hygie of other event,	Ö	17. Father's Name (First, Middle, Les	"			OUDTIE		18. Mothe	er's Name	e (First, Middle	. Maiden				
an	Mental Mental arked o	o Be														
\geq	d Me d Me merk	۲	CLARENCE H. BAN: 19a. Informant's Name/Relationship			40h Mailine	Add (C				TA I H		- T C4	-4- 7:-	Codel	
Z	nd 2 should be Ith and Mental 17 is marked o traumatic eve	-									el Route Numb					1070
		- H	Sylvia Murphy/Sis [.] 20a. Method of Disposition	ter	20h Pla	65⊥ ca of Dispos		_	St.,	Apt	3, Ha					10/8
ō	or in		20a. Method of Disposition 1 ∰Burial 2 □ Cremation 3 [Removal from State	cer	netery, crem	etory or othe	r plac	ce)	I	Date	200. Lo	cation - Ci	ty or low	n, State	
Ē	ح ن <u>ہ ج</u> ہ		4 ☐ Donation 5 ☐ Other (Speci		BEI	RKLEY	CEMETI	ERY		8	-8-07	DARI	LINGT	ON,	MARYL	AND
Baltimore,	permit. Per Departmen Important: any injury once.		21. Signature of Funeral Service Lice	nsee			Name and A				Y FUNE	מאד ב	JOME-1	ם אום ביי	OBD	D 7\
•	20 = 5 8		Bashana (MANIN.							BLVD,					
		-	23a. Part1. Enter the disease, or com	plications that caused	the death.	,								1	Approximat	Θ
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									ween Death				
4	/Medical		Immediate Cause (Final	Mran.	. \ (7	0 /	•						İ		
	Examiner		disease or condition resulting in death)	a Myoca) hance	on								
,		9	Due to (or es e consequence of):													
/	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):							1						
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760	sicia bur	ie l	Cause (Disease or injury	c	D . 4. /		0									
68760,	artificetu ing phy e as the	8	resulting in death) Last		Due to (or a	s a consequ	эпсө от):									
Box	T 5 0	2		d												
Ö	v requires that tha death ce been signed by the attendi should be detached for us.	Completed by Physician/	2 (1) 24 1 27 1 27													
P.O.	tha d the ched	lys.	Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ing in the und	lerlying caus	e giv	en in Part I.				1		the cause	
٩	that t ed by deta	٣									10	Yes 2	No 3	☐ Prob	ably 4	Unknown
ds,	sign d be	ह									0.4- 14/			Ab Wo	e autopsy f	lindings
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ec	5 V N	힏										t		of d	eath?	
Ē	The ata h paga	် ဂ									10	Yes 2	No	1 🗆	Yes 2□	No
Division of Vital Records,	slam: ertific	Be	25. Was case referred to medical examiner?					1 -		of Death	(Check only	оле)				
=	hysic nis c	၉	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		7/Outpatient	3□ DOA	Oth	4 DUNU	rsing Ho	me 5□Resi	idenca 6	3 □Other	(Specify)		
0	ng Pl	<u> </u>	27. Manner of Death 1 Manual 5 ☐ Pending	28a. Date of Injui (Month, De)	y Year) 2	8b. Time of Injury	28c.	Injun Worl	y at k?		28d. Describe	how injury	y occurred			
Ö	Attending in death. actor: After by the fune	ä	2 Accident investigatio				М		Yes 2□	No						
<u>S</u>	After der der by t	Ĕ 	3 ☐ Suicide 6 ☐ Could not be determined	e 28e Place of Inju	Jry - At hom	e, farm, stree	t, factory, of	ffice			28f. Location (City or To			or Rurel	Route Num	ber,
	safter sa	Certification:			(-///											
	bound In fill	E Ca	29a. Certifier Certifying Ph	ysician: To the best of	f my knowle	edge, death o	occurred et ti	he tin	ne, date an	d place, a	and due to the	cause(s)	and mann	er as ste	ted.	
	To the Hospital within 24 hours To the Funeral completely filled	edicai	one)	niner: On the basis of and manner sta	ted.	n androi inve	anyamon, in	my of	pariiori, deal	ar occurr		Jate and	place, enc	- due 10	ine cause(S	
	To t With To t	≥	29b. Signature and title of cartifier	14			29c. Li	cens	e number			29d. Date	e signed (/	Month, D	ey, Year)	
) / 4 /	Hou			105	54	073			0	7-31	1-0	1	
•	D.		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, P	rint)									
	3		Arley Store	MD - UM	917		c Hman	1	()	2	NEW	6457	LE	DE	197	120
	Stat	e	31. Date filed (Month, Day, Year)	32 Registra	ar's Signatur						/ -					
	Registra	ır	31. Date filed (Month, Day, Year) AUG 0 2 20	UT The same	, K	Direc	85									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh 870 8-7-07 vt. State of Maryland behariment of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) a Day 2.000 10:25 PM Physician Braxton lova 5 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Rattemana Rahabilitation Extended 4b, City, Town, or Location of Death Examiner Baltimore Rehabilitation NIA BALTIMURE 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 24 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** Min 1 M M 2 □ F 7-62-146 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director amore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 Funeral American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: L ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) outer Chnic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cell tery, Garan Crother place) Date Dundal K or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 200 3 □Removal from State 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral le Balto. Joseph W. North Ave 23a. Part I. Enter the Irlease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is the following one cause on each line.

Immediate Cause (Final disease or condition Metastatic Head and Neck Squamous Celusiesaes or condition (ell Immediate Cause (Final disease or condition resulting in death) arcinoma **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number D 4 1365 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheorge E. Wicks III M.D. 3900 Loch Raven Boulevard, Battimore, MP, 21218 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ruby Bertina Bailey 10:40a M 29,2007 July. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Genesis Healthcare Collegeview Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 474–26–7432 7. Age (In yrs. last birthday) 96 Yrs. Birthplace (State or Foreign Country) Months 1 □ M 2 □ XT March 26,1911 ND

10f. Zip Code

1 ☐ Yes 2XNo

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

Somerset

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

54025

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Ragna

216 Aspen Drive, Somerset, WI 54025

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8/3/2007

10d. Inside City Limits

10g. Citizen of What Country?

14. Race - American Indian

Own Home

White

Black, White, etc.

USA

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

Taralseth

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Year

. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

2007

21702

Month

Roseville, MN

1 XYes 2 No

10c. City, Town or Location

Funeral Director ral", or items 23a or 28a-f show Examiner must be notified at death filed within 72 hours after Hygiene. 3altimore, Maryland 21215-0036 "natural" traumatic event, the Medical 2 should be filed within 7 and Mental Hygiene. of the start of th Pages 1 Department of Important: If it any Injury or conce.

Physician

/Medical

Examiner

Usual Residence of Decedent

10e. Street and Number

1 Never Married 2 Married

3 ₩ Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Hans A. Sather

19a. Informant's Name/Relationship (Type. Print)

Day, JG Year)

2 2007

31. Date filed (Month.

Steve Bailey / Grandson

1 ☐ Burial 2 ☐ Cremation 3 X Removal from State

11

20a. Method of Disposition

216

11. Marital Status

10b. County

Aspen Drive

St. Croix

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U.S Armed Forces?

2 X No

1 ☐ Yes 2 ∑ If Yes, Give Year or Dates:

College (1-4or 5+)

10a. State

WI

Director

Funeral

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Completed

Be

ပ္

Physician /Medical Examiner

the death certificate be executed

law requires that

The I

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To the Hospital within 24 hours a hours

Box 68760,

P.O.

or Vital Records,

Division

attending physician and for use as the burial-transit signed by the at a be detached fo pate has page 2 s funeral director, After nours after death.

neral Director: A
filled in by the fu

Roselawn Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final exhive ailure disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ 160 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 Probably 4 Unknown Completed 24a. Was an autopsy perform 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ပ္ 1 ☐ Inpatient 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) nd title of certifier 29b. Signatute MI D0060417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick C Thomas Tohnson Shah Dr

32 Registrar's Signature

State Registrar

17

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 31 Birtukan G. Beyene 07 2007 9:57 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 F 218-61-7701 40 Director Ethiopia 4-27-1967 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. As the waster 127 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show ant; Ite Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Rockville Funeral Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12520 Veirs Mill Rd. 20853 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gebre-Amlak Beyene Etunesh Abebe ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Degene W-Tensaye/son 12520 Veirs Mill Rd.#103 Rockville, MD 20853 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page: Department o Important: If i any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 8-3-2007 Silver Spring,MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MD 20910 Rapp Funeral & Crem. Svc 933 Gist Av Silver Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast anco /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence cf): Division or Vital Records, P.O. Box 68760, physician attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) has been signed by the ge 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an , page certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this (funeral dir Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: tely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 P one) and manner stated, 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00064615 4) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, MD 20853 n32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 6:07 PM Curri 0 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3altimare 5. Social Security Number 6. Sex Baltime A Medical center Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 216-84-7720 1 M 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show iral", or items 23a or 28a-f show Examiner must be notified at Baltimore 1 Ves 2 No Director MP 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 2500 W. Avenue 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giver Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural"; 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gromen YGNR 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be LAUDE ဂ္ 19a. Informant's Napay/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOTHEN 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition

1 Burial 2 remation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service in see Approximate Interval Between Onset and Death 3a. P. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. mediate Cause (Final **Physician** Sady Cardia mayte disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy certificate has been signed by the atter rector, page 2 should be detached for i Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? $\mathcal{O}(\mathcal{K}) \neq \mathcal{O}(\mathcal{L})$ vision or Vital Records, ģ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy U se Cocame 1□ Yes 25. Was case referred to medica examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) æ Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Marmer of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation Injury To the Hospital or Attendi within 24 hours aller death. To the Funeral Director: // 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

(Check only one)

29b. Signature and title of certifier

tor

68760

Box

P.O.

Greene

Registrar's Signature

The State of

29c. License number

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death CAGOR EVELYN VIOLA Month **Physician** 27,2007 IMLY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITAL BALTIMORE SAINT AGNES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 25€ 90 **Director** MARCH 17. MARYIAL Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Heatth and Mental Hygiene. Innortant; or items 23a or 28a-f show innortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at once. 1 □Yes 2 No ElkribGC Director MARY LAND 10e. Street and Number 10g. Citizen of What Country? 21071 7220 Monta om ony Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Ite 1 ∐Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Blacks þ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homo 8th grack 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NICKOLSUN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORCHESTER 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Elknoss, Mary land 07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License TUNGASI Hon & KETS TENSTOUS Plans Bothney Mel 213. ours sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, liure. List only one cause on each line. 23a. Part1. Enter the mmediate Cause (Final disease or condition Physician CARDIOGENIC SHOCK 2 HOURS resulting in death) /Medical Examiner INFARCTION MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-tram Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No STAGE RENAL DISEASE 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I To the Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XInpatient ၉ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P20656 JULY 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 21229 KONSTANTIN ZUBELEVITSKIY

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 0 2 2007



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** august 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimare (1)
If Under 1 Year | If Under 24 Hrs. Ba N/A 9. Birthplace (State or Foreign 6. Sex 8 Date of Birth (Month, Day, Year) Social Security Number **Funeral** Country) VIRGINIA Days Hours Min. 1 XM 2 ☐ F 3, Director 56 MAY 223-68-2026 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 U.S.A. 1600 NORTHWICK RD. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Interportant: If Item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines ODRE. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 Specify Specify: BLACK þ 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A DISABLED 12th grade 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KATIE VICTORIA BLACKWELL WILLIAM RUBEN CROCKETT SR. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21218 3807 Rexmere Rd., Mildred C. Davenport/Sister altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08-06-07 BALTIMORE, MARYLAND KING MEMORIAL PARK 21. Signature of Funeral Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. wown 1206 W NORTH AVENUE 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Vr 11 months (an /Medical Due to (or as a consequence of): Examiner ENJ-54 age & Sequentially list conditions, and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ H0 24a Was an autopsy performed Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No thours after death.

-uneral Director: A

ely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD PhD 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) more MD 600 Hagan Wolfe 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 0

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Dep		lental Hygi	ene2007	24718
	> #		1 - State Registrar Amend #30, perDVR G870, 8/2/07 TT Ce	Tuncale of Death	2. Date of Death	g. No.	3. Time of Death
	Physicia	an			Month	Day Year	M
	/Medic		Ralph A. Click 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July	20 2007 4c. County of Deat	3:50 P [™]
	Examin	er	NMS Healthcare of Hagerstown				
<u>~</u>	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	Hagerstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washingto	hplace (State or Foreign
	• Director		230-92-0805 Y□M 2□F 70 Yrs.	Months Days Hours Min.	(Month, Day, July 7,	Year) Co.	_{untry)} rg inia
the Said	D		Usual Residence of Decedent		100117 73	1757 171	
	irylan show	_	10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits
	e Ma Ba-f s	cto	MD Washington Hagersto	wn			1 □ Yes 2¶ No
	or 2 be no	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	be filed within 72 hours after death with the Maryland Hyglene. id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ral	14014 Marsh Pike	21740		USA 14. Race - Ame	dana tadina
	ltem Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ②CNo	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
30	rs aff I', or xami	by F	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 🏋 No Specify:		Specify:	White
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Mary	12 should be filed w h and Mental Hygie 7 is marked other ti raumatic event, th			ing Address (Street and Number or Rui			
e •	l and dealth dm 27		Tommy Higgins 21 1 20a. Method of Disposition 20b. Place of Disp		dericksbu	oc. Location - City or	22405
Ď	ages or of l		cemetery, cre	ematory or other place)		Exadordo	ksburg, VA
Baitimor	it. Pa rtmer rtant njury			ptist Church July		, Fledelic	ASDUIG, VA
g	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic evonce.			2. Name and Address of Facility OVENANT FUNERAL SE			
			23a Part1 Enter the disease or complications that caused the death. Do not en	301 JEFFERSON DAVI	S HIGHWA' or respiratory arre	Y, FREDRIC	K, VA 22408 — Approximate Interval Between
	Dhuaición		shock, or heart failure. List only one cause on each line.	- 100 0	A .		Interval Between Onset and Death
	Physicián /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	ion Ingli	mon.		
	Examiner		Frosiva	Esopha	gi tis		
ij.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,		
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8/60	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical	d				
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J.	that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords,	quires n sigr	d by	mental Retard	Latin	1 □ Ye	s 2□No 3□Pr	obably 4 Denknown
ပ္ပ		lete			24a. Was an	24b. Were au	utopsy findings available completion of cause of
r	slcian: The law certificate has t irector, page 2 s	ompleted			autopsy perform 1 Yes 2	pnor to death? □ I □ Yes	
<u>Kal</u>	lan: rtifica stor, p	Se C	25. Was case referred to medical	26. Place of Dea	th (Check only one	/	20,10
o_ 	hysic nis ce direc	To B	examiner? 1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing H	ome 5 Reside	nce 6 □Other (Spe	cify)
0	ng Pl		27. Manner of Death 1 ☐Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe hor	w injury occurred	
<u>0</u>	tendi eath. tor: A the fu	cati	2 Accident investigation	M 1 Yes 2 No			
UNISION	or At fter d Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (Str City or Town,	reet and Number or Ru , State)	ural Route Number,
_	pital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the ca	use(s) and manner as	s stated.
	e Hos 24 ho e Fun letely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	To the Hospital or Attending Physician: within 24 hours after dear. To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director, the funeral director director, the funeral director, the funeral director director, the funeral director director, the funeral director director, the funeral director director director director director, the funeral director di	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont	
	0		Jains muchus	9060391	5	07/23/0	```
	$ \begin{bmatrix} \end{bmatrix} $		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
	l		Farid Murshed, MD NMS Healthcare of Hagerstown	n, Hagerstown, MD			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 2007 32. Registrar's Signature	horales			
	negisti	al	AUG V Z LOUP BROKE SO.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth Month, Day 9. Birthplace (State or Foreign Social Security Number Age (In yes. last birthday) **Funeral** 10-034 Days 1 M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 5 is other traumatic event, the Medical Examiner must be not other traumatic event, the Medical Examiner must be not d 2 Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ø No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Callege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) (Grand Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location -Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed physician and s the buriaf-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. SS IF FEMALE nse yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) ed by the a 9☐Unknown 9 Unknown this certific te has been signed by ral director, bage 2 should be detac 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 4 Onknown 1 ☐ Yes 2 □ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence ner (Specify funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury 28c. Injury at Work? occurred After 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury 1 □ Yes 2 □ No after death.

I Director: A
d in by the fu 2 ☐ Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of State 31. Date filed (Month Registrar

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ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAHLD SHAMIM, ND. WASHWGTON ADVENTIST 32. Pagistrar's Signature 2007

29c. License number

29d. Date signed (Month, Day, Year)

For

State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-1 ehow eny injury or other treumatic event, the Madical Examiner must be nutified at 2008.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours effer death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Registrar			Cen	tificat	e of L	Jeath			Reg. I	No.			
	1. Decedent's Name (First, Middle, Li	ast)							2. Date of D				3. Time of Death	3
n al	Robert J. Falls								July 1	ο, ٔ	2007	Year	9:50 AM	М
r	4a. Facility Name (If not institution, gi	ive street and number)			4b. City,	Town, or	Location	of Death			4c. County	of Deat	h	
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		Sex 7. Ag 1 ☑ M 2 ☐ F	e (in yrs. last b		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Dec 25	rth ay, Yea	ar)	9. Birtl	nplace (State or Fore untry)	ign
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Funeral Director	826 Brunswick Roa	ad #2A					21221	1			US			
era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	/as Deced	dent of Hi			cify Yes or N Rican, etc.)	0-	14. Rac	e - Ame	rican Indian,	
	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔯							Rican, etc.)			k, White		
ò	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes	2 <u>X</u> No	Specify:				Specify	· wh	ite	
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Re	17. Father's Name (First, Middle, Las								(First, Middle	e, Maid	len Sumam	10)		
2	Albert Sidney Fa					-			Gross					
İ	19a. Informant's Name/Relationship								I Route Numi		-		(ip Code)	
-	Barbara A. Falls 20a. Method of Disposition	/ spouse	20b. Place				Roa		Essex	_		.221 City or	Town, State	
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	in stat	cemet	ery, crem	atory or o	ther plac								
	21. Signature of Euneral Service Sice	wade Dir	ector	St. Ba	Name an ate 1 1timo	d Addres Anato	ony B	oard 21201	655 W	. Ва	altimo	ore	Street	
	23a. Part1. Enter the disease, or con shock, or heart failure. List ont	mplications that cause	d the death. Do							arrest,			Approximate Interval Between	
	Immediate Cause (Final disease or condition	(00	T)										Onset and Death	
	resulting in death)	Due to (or as	a consequence	B of):										
	Sequentially list conditions	b												
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):										
E	that initiated events resulting in death) Last	C. Due to (or as	a consequence	a of):										
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/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy								23d. Dat	te of deli	VAN	
clar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetel death		Ectopic pr Other (sp						Mo		Day Year	
Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown												
	Part II. Other significant conditions	contributing to death t	out not resulting	in the un	dertying c	ause give	en in Part I	l.	23e. Did	tobacc	co use cont	ribute to	the cause of death?	1
Completed by	COPD								1	Yes	2 🗆 No	3 ☐ Pr	obably 4 Onkno	wn
Jet	Hypertension								24a. Wa		24b. \	Were au	topsy findings availa	ble
E	111111111111111111111111111111111111111		·						auto peri 1 ☐ Yes	opsy formed 2-2	?/	death?	completion of cause	or
Re	25. Was case referred to medical						26. Place	e of Death	(Check only		140	63	<u></u>	
0	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Inpati	ent 2 ERVC	Outpatient	3 🗆 DC	Othe	25		ne o Res		6 □Oth	er (Spec	cify)	
	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju	ury 28b	. Time of Injury	2	8c. Injury	at	2	28d. Describe	how in	njury occuri	red		
ä	2 ☐ Accident investigati	on			М		Yes 2□	No						
₩	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	A 289. Place of In	jury - At home, tc. (Specify)	farm, stre	et, factor	y, office		2	28f. Location City or To	(Street	and Numb ate)	er or Ru	ıral Route Number,	
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edical Certification:	29a. Certifier (Check only one) 29a. Certifier (Check only one)													
Se Se	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)													
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	30. Name and address of person who	o completed cause of	death (Item 23a) (Type, F	Print)						v l			
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e	31. Date filed (Month, Day, Year)	32. Fishist	rar's Signature		-						-			

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200° /Medical 4a. Facility Name (If not institution, give street and nymber) Examiner 4b. City, Town, or Location of Deat 4c. County of Death land Greneral Hospita Baltimore If Under 1 Year | If Under 24 Hrs. | 8 9. Birthplace (State or Foreign Country) Mary land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours /57-36-48/8 Usual Residence of Decedent 1 M 2 □ F 60 Director Yrs. with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director 15 altimos Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 121 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "naturel" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 end 2 should be in nent of Heelth and Mental is ant: If item 27 is marked o Suster Coug 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ette Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ō Depertment of Important: If eny Injury or ones. 4 □ Donation 5 □ Other (Specify) en atonsville 21. Signature of Fun and Service Licensee hatman val. Home Harris + to auro evoy StowA MUS DIDIS STEI 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of): **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): Physician/Medical sate has been signed by the attending phys page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification; To Be Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death. To the Funeral Director: , completely filled in by the f within 24 hours a To the Funerel L To the Hospital

> NUACHUKNU, MD 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Nwachukuru, 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

6 Could not be determined

3 Suicide

29a. Certifier

Medicai

4 Homicide

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Registrar

12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and class and due to the nause(s) and remains a stated
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of Mary		epartment of the Certificate of		na Mentai H		2007	24723
Physic	ian	Decedent's Name (First, Middle, La					2. Date of I Month	Death Day	9 200°	3. Time of Death
/Medi		4a. Facility Name (If not institution, giv		\circ	4b. City, Town, o	or Location of	Joly Peath	4c. (ounty of Deat	
		BALTIMORE WASHING					JURUIE			RUNDEL
Funeral Director		212-52-2783	Sex V 7. Age (III I M 2 □ F 52	n yrs. last birth Y	rs. If Under 1 Year Months Days		Min. (Month,	Birth Day, Year) 195	Co	hplace (State or Foreign untry) LAND
land bw tt		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location					10d. Inside City Limits
Africa af sh	tor	MARYLAND ANNE ARU	JNDEL	ODENTO	N					1 ☐ Yes 2 🖾 No
ith the or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
sath w s 23a nust b		1301 WICKELL RD	12. Was Decedent Eve	rin II C	21113		in 2 (Coosify Van out		ED STAT	
hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes, Give Year or Dates:	1 11 0.3.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 汉 No		Puerto Rican, etc.)	1	Black, White Specify:	e, etc.
, 52 E 53	ted	15. Decedent's E (Specify only highest gr.	ducation	16a. [Decedent's Usual Occu (Give kind of work done	pation	of working	16b. Kin	WHI nd of Business/	
within 72 ho giene. r than "natu	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work done life. DO NOT use retire	ed)	or working		CMD T C 3 T	
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lid be lental ked o	o Be	CHARLES F. GESCH	,				ERINE ELIZ			
and M s mar	-	19a. Informant's Name/Relationship		19b.	Mailing Address (Street					Zip Code)
and and and and and and and and and and		LAI FU GESCHWILM/			01 WICKELL	RD.;	ODENTON,		1113	
permit. Pages 1 and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, the Medonice.		20a. Method of Disposition 1 ☐ Bugal 2 ▼Cremation 3 ☐ 4 ☐ Doctation 5 ☐ Other (Speci	Removal from State	cemetery	Disposition (Name of crematory or other plants	A	UGUST 3,	CATO		Town, State MARYLAND
permit Depar Impor any In		21. Signature of Fune all Service Lice	\mathcal{N}		421 CRAII	WY.		N BURN	PA NIE, MD	21061
		23a. Part1. Ster the disease, or conshock, or heart failure. List only Immediate Cause (Final	plications that caused the one cause on each line.	e death. Do no	ot enter the mode of dy	ing, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical	ı	disease or condition resulting in death)	a. Due to (or as a co	onsequence of						12 HOURS
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sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Line Underwing Cause (Disease or injury	Due to (or as a co		f):					
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The law requires that the death certivate has been signed by the attending bage 2 should be detached for use a	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □ Ectopic pregnand 5 □ Other (specify) _	су		- 2	3d. Date of del Month	ivery Day Year
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Attending Physician: Treath: Treath: Pector: After this certifical by the funeral director, p	Be C	25. Was case referred to medical examiner?	1 loopital				of Death (Check onl			
Physi this c	٠ <u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Impatient 28a. Date of Injury	2 ER/Outp	patient 3 DOA		rsing Home 5 Re			cify)
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To the Hospital or Attend within 24 hours after death. To the Funeral Director: v. completely filled in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	e 290 Place of injuny	- At home, fan Specify)	m, street, factory, office			(Street and Fown, State)		ural Route Number,
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in I	edical C	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of ex and manner stated	amination and	death occurred at the tl/or investigation, in my	time, date and opinion, dea	d place, and due to t th occurred at the tin	ne cause(s) ne, date and	and manner as place, and due	s stated. e to the cause(s)
To the within To the Comp	ž	29b. Signature and title of certifier				se number		29d. Date	e signed (Mont	h, Day, Year)
		(millenno). Cu	ongrees 40		000	e5+10	+	200	1 54,5	F00.
(9)		30. Name and address of person who	E CINDEREC	:0 3	ATISOH 10	DRIV	4312,3	iugo B	E, ND ?	ro/c/
St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	Coard					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 9870 8-7-07 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0215 2007 Gibson A GROVGE Inch /Medical 4a. Facility Name (If not institution, give street and number) 5505 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Care Center, Hopkins Boy likele Buttimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10-26-1935 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months Hours Min. 1**X** M 2□ F Maryland 213-30-7731 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a edical Examiner must b 21047 U.S.A. 2404 Stoneybrook Rd Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2M Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed within Health and Mental Hygiene. Plastic Company Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathryn Ann Kilbey Gene Henry Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages I an Depertment of Health Important: If Item 27 any Injury or other tra once. Rita Gibson (Wife) 2404 Stoneybrook Rd Fallston, MD 21047 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 7-25-2007 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 < me 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death vespivatory failure Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) 10 m Examiner lung concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ld be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, þ Premonia 1 ☑Yes 2 No 3 Probably 4 Unknown tongue cancer Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed certificate 1∐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD, OhD D 0054067 July 22, 2007 MD Seul VOD.V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEVIL YAJAIL, MD Hopkins Bayview Circle, Battimore MU 21224 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 2 2007 Registrar

DHMH 17 Rev 1/2001

SHIRELL GREGORY Baltimore, Maryland 21215-0036

			Please	Type or Prin									le.	
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	-		Decedent's Name (First, Middle, Last	st)						2. Date of De	eath	Control of		3. Time of Death
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Н	Funeral		5. Social Security Number 6. S 577–88–4213	ex 7. Ag □M 2√F		last birthday) Yrs.	If Under 1 Yea Months Day		r 24 Hrs. Min.	8. Date of Bi (Month, Di	rth 1 a <i>y, Year,</i>	961	Coun	lace (State or Foreign try)
	Director		Usual Residence of Decedent	AA	45					Decemb	er 1	2,	Wash	ington DC
	/land ow at		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	a-f sh ified	ctor	District of Colum	oia	1	Washin	gton							1 XYes 2 □ No
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	er dea	nue	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 24	Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic O ban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Black,	· America White, o	
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nd	be file tai H) d oth event	a	17. Father's Name (First, Middle, Last)							(First, Middle		n Surname))	
Maryland	12 should be filed withir h and Mental Hygiene. 7 is marked other than traumatic event, the Me	T ₀	Arthur Van Brakle			1				latthew				
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (*) Sarah Van Brakle/			19b. Mailir 2231	ng Address <i>(Stree</i> 12th Pl	and Numi ace N	berorRura W. Was	al Route Numb shingto	n DC	or Town, Si C 2000	tate, Zip)9	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. P		sition (Name of matory or other p			ate		ocation - C		wn. State
Baltimore,	Pages nent of I nt: if its iry or o		1 ⊠ Buyal 2 □ Cremation 3 □ 4 □ Denation 5 □ Other (Specifi				natory or other p Memorial	ace)	Augus	t 3,			-	
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	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fo		29a. Certifier Certifying Ph	ysician: To the best niner: On the basis o	of my know	wiedge, deatl	occurred at the	time, date a	and place, a	and due to the	cause(s	and man	ner as st	ated.
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_	2 1		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	29c. Licer RE Print) 9 MARI	TAN	nas	PITAL	M	ARY	LA	ND
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Milkers Gupton July 25,2007 1:07 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gladys Spellman Nursing Center Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month Day Year)
May 3,1952 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 240-90-8542 1**★** M 2 🗆 F 55 North Carolina Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 Yes 2 No Virginia Fairfax Annandale Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6710 Captain Drive, 22003 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1

Mever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Twe1th Boiler Cleaner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental I aut: If Item 27 is marked o Annie Mae Wiggins Edward Gupton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6710 Captain Drive, Annandale Virginia 22003 Janet Green/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 30. 2 ☐ Cremation 3 TRemoval from State t Buris permit. Page Department of Important: If eny Injury or QDGE. 4 □Donation 5 □ Other (Specify) 2007 Family Cemetery Lewisburg, N.C. re of Fundal Service Licarisee 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signat 1661 Good Hope Rd SE, Washington DC 20020 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pneumonia **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, flany, loading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed ete has been signed by the attending physician and page 2 should be detached for use as the burial-transit Human Immunodeficiency Virus that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Tyes 2 No 1 Tyes 2₩ No Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending death. М 1 Tes 2 No 2 Accident investigation after death Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral E 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0026024 July 25,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lester Miles, MD 6430 Landover Road, Landover Maryland 20785 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 2 2007 Registrar

07-05707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lichael Curtis Gor		State of For State	Maryland / De	epartment C <i>ertificate</i>		nd Menta		eg. No. 20	07 24.72
Physician	_	Decedent's Name (First, Middle,Last)					2 Date of Deal	th	3. Time of Death 1210 hrs
Medical Examine		Michael Curtis a. Facility Name (if not institution, give str			4b. City, Town,	or Location of	Month July 25, 20	4c. County of De	
	-41	456 Caledonia Avenue	30. 3.13 No.112 117		Halethorp			Baltimore C	
Funeral Director	5	Social Security Number 218-62-0130 6. Sex	7. Age (In y	yrs. last birthday 54) If Under 1 You Months Da			th(MM/DD/YYYY) 9. 7/1953	reign MD
www.	. —	Sual Residence of Decedent Oa. State 10b. County MD Baltimo		City, Town or L Haleth				3.7	10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once		Oe. Street and Number	16		10f. Zip Code		1	log. Citizen of What	
the Mary a or 28a	2	456 Caledonia A	ve.	`	2122	27		United S	
more, MD 21215-0036 Pages 1 and 2 should be flied within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once.	-nue	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? Yes 2 Yes Give Year	No.	Was Decedent of If Yes, specify Cub	an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	White, e	merican Indian, Black, tc. White
ours'afte	ଜ⊢	15. Decedent's Education (Specify only	Dates'	ad) 16a Dec	edent's Usual Occu	pation (Give k	tind of work done use retired)	16b. Kind of Busin	ess/industry
36 in 72 ho ban "n	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		dio Tecl			Automo	otive
MD 21215-0036 at 2 should be filed within 72 lith and Mental Hygiene. In 27 is marked other than aumatic event, the Medical	통 -	17. Father's Name (First, Middle, Last) Dennis Gore					s Name (First, Middle,		
2121 uld be fil Mental I marked	10.Be	9a. Informant's Name/Relationship (Type	e, Print)			reet and Num	ber or Rural Route Nu	mber, City or Town,	State, Zip Code) 50310
MD and 2 show that and 2 show the show	L	Jared Gore/Son		- 1	/1 NW 50			20c. Location - C	oines, IA
Baltimore, MD 21211 bernit Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	crematory Chesap	or other place) eake Cre	οςγ emat	July 27 2007	Beltsv	ille, MD
Baltimo permit. Page Department or Important: injury or oth	1	21. Signature of Funeral Service License	0 100	1358	Cremat: 8717 Gr	ion an een Pa	nd Funera	Alter	natives imore, MD
Physician M-dical	10	23a. Part I. Enter the disease, or complic failure. List only one cause on each	ations that caused the line. therosclerot				ardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death
xaminer			ue to (or as a conseque						
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a conseque	ence of):					
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te be executed te be executed sysician and burial - transit	edical	X UNPENDED	##5\PFPII,27,	perME,g87	O, 8/9/07 T	Τ		les p	
O. Box 68760 that the death certificate be the attending physidetached for use as the bu	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live birth Pregnant at tim	2	Fetal death Other (Specify)	3 Ectopi	ic pregnancy	23d. Date of d Month	Day Year
	hysic	1 Yes 2 No 9 Unknown	g Unknown			an siyan in D	ort L 23a Dio	tobacco use contrib	ute to the cause of death?
P.O. s that the	2	Part II. Other significant conditions of Diabetes mellitus	contributing to death bu	ut not resulting i	n the underlying cal	ise given in P			Probably 4 V Unknown
ords, P.C w requires that as been signed?	Completed	2145000 110122000						topsy pr	ere autopsy findings available ior to completion of cause of
Recol The law cate has	gmo						1 ✓ Ye		eath? Yes 2 No
Vital Rec ysician: The his certificate director, page	Be		ospital: 1 Inpatient	2 ER/Out	26.F patient 3 DOA	Other:	(Check only one) Nursing Home 5	Residence 6 🗸	Other: Scene
. f te	tion: To	1 ✓ Yes 2 No 27. Manner of Death 1 ✓ X Natural 5 Pending	28a. Date of Injury (Month, Day, Year) 28b. Tii	,,,,,,,	Injury at Wor	No	oe how injury occurre	
Division al or Attendars after death al Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not b determined	28e Place of Injur	y - At home, farr	n, street, factory, of	fice building, e	etc. 28f. Location or Town	n (Street and Numbe n, State)	r or Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner:	n: To the best of my k	nowledge, death	occurred at the ting estigation, in my op	ne, date and p pinion, death o	place, and due to the concourred at the time, da	ause(s) and manner ate and place, and do	as stated. ue to the cause(s)
To with To con	Med	29b Signature and title of certifier	and manner stated.	مر ـــا	29c. L	cense numbe			ed (Month, Day, Year)
2 of pend		30. Name and address of person who c		th (Item 23a)	ner 111 Pen	n Street F	Baltimore, MD 21	201	
	ate	Patricia Aronica-Pollak MD 31. Date filed (Month, Day, Year)	32. Registrar's						
Regist	trar	31. Date filed (Month, Day, Year) AUG 0 2	2007	es St.	greek)				
DHMH 17 Rev 1/28	001	nr	AAC .	ORI	GINAL				

Registrar

State

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31,

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DR. EDDIE NAKHUDA

31. Date filed (Month, Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Warviar of Department of Hearth and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 Day Physician 1:25 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, 3 19 9. Birthplace (State or Foreign Country)

NORTH CAROLINA 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🗙 F 238-58-7410 Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE Be Completed by Funeral Director 10g. Citizen of What Country? CIANAMON CIRCLE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Never Married 2☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COOK BAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BURNETT HARDING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/133 19a. Informant's Name/Relationship (Type. Print) H CIANAMON CIR RODNEY Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Woodlawn Cemetery 8-6-07 4 □ Donation 5 □ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility DHILLIP E. OLIVER ST Approximate Interval Between Onset and Death 23a. Pa /l. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Immediate Cause (Final dise se or condition resulting in death) renal days **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 (No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ★ No 24a. Was an autopsy performed? Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Peath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053928 07/21/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURATYA BELUM, A 2434 W. BELVEDERE AVENUE, BALTIMORE, MD -BELZUM, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Paistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dwr g8/0 8-2-0/ vt.

State of Maryland P Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 5, Margaret Hodges 2007 12:35 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Health & Rehab Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Sept 14, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕏 F 79 Director 238-22-9903 Usual Residence of Decedent the Manyland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show ortant: If itam 27 is marked other than "natural", or Items 23e or 28a-1 shov injury or other traumatic event, It a Medical Exertment mark be notified at 1 ☐ Yes 2√ No Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 5721 Grosvenor Lane USA Funeral 12. Was Decedent Ever in U.SUNK
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give

1 ☐ Yes 2 ☑ No
If Yes 2 ☑ No
If Yes 2 ☑ No
If Yes 2 ☑ No
If Yes 2 ☑ No
If Yes 2 ☑ No
If Yes 2 ☑ No Specify: unk 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ If Yes, Give Year or Dates: Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file timent of Health and Mental Hitant: If item 27 is marked out unk 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bethesda Health & Rehab 5721 Grosvenor Lane Bethesda, MD 20814 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. '4 Donation 5 MOther (Specify) in state 21. Signature of Europe Licensee Ronal S. Ward 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director m Mule Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** LYMPHOMA Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 Physician/Medical the attending for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? /es 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onli one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this To tha Funaral Diractor: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours a To the Funeral L To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) unBes, uno 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao 9715 Medical Center Dr. Rockville, Md. 20850 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2007

			1 - For State Registrar	State of M	arylan		artmen <i>tificat</i>			and M	lental H	ygien Reg. N	LUI	24	731
П	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of I Month		ay Year	3. Time	of Death
	/Media		Mary Ann Hofmei								July		2007	10:07	AM M
	Examir	er	4a. Facility Name (If not institution, give						Location o	of Death		4	c. County of Dea		
			6451 N. Charles 5. Social Security Number 6. Sec			ast birthday)	Tow:		If Under	24 Hrs	8. Date of E	linth	Balti		or Cornian
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	how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	
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	ith th		10e. Street and Number				10f. Zip					10g. C	Citizen of What Co	ountry?	
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	iten de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💢	,	5. 13. Y	Yes, spec	ent of His	n, Mexican	gin? (Spe), Puerto	ecify Yes or I Rican, etc.)	NO-	Black, Whi		
936	Ir, or	۵	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2 ∏ No	Specify:				Specify: T	hite	
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<u>o</u> E	Pages ent of t: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☑ Other (Specify)	emoval from State	Ce	emetery, cren	natory or o	ther place	9)						
Baltimore,	permit. Pages. Department of the Important: If its any injury or of once.		21. Signature of Funeral Service Licens Onald S	ade, Dir	ector		Name an tate			Board 2120		W. B	altimore	Stree	t
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Division of Vital Records,	nding Physiath. ath. r: After this ce funeral dire	၉	1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending 2 Accident investigation	lospital: 1 Inpati 28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury		8c. Injury Work	4 📙 Nu	1	me 5 ☐ Re 28d. Describ		Other (Spenury occurred	icity) ASS UTE	ed living Facility
Divis	s efter des at Diracto ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At ho tc. <i>(Specify</i>	ome, farm, str	eet, factory	r, office		1		(Street a	and Number or R	ural Route Nu	mber,
	To the Hospital or Attending Ph wikin 24 hours eiter death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis of and manner st	of examinat	wledge, death tion and/or inv	occurred restigation	at the tim, in my op	e, date an inion, dea	d place, a th occurre	and due to the	e cause(e, date a	(s) and manner a nd place, and du	s stated. e to the cause	(s)
)	To t com	Σ	29b. Signature and title of certifier)			290	License	583			70	Pate signed (Mon.		
			30. Name and address of person who co	us mo	0701	NC	Print)	SC	1	10W	79N V	10	21204	4	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 2 20	32. Registr	rar's Signal اکمہ المستخام	ture	rech	>							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19b per 15 9870 8-17-07 yt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 2007 **Physician** Mary E. Holland 28 5:54a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview N.H. Essex Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 M 2 T 144-24-9202 78 Director 8-18-1928 N.C Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 √Yes 2 No Director Md. Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 1 Eastern Blvd. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 27 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black <u>۾</u> Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) the Jewish Conv. Home 12th grade Nursing Asst. other 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental F Holland Elizabeth Madison John Frank Cherry ဥ 19b. Maijog Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3723 Delk Court, Turner Station, Md. 212 19a. Informant's Name/Relationship (Type. Print) f Health a Item 27 i 21222 Linda White Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H
Important: If Ite
any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Middleriver, Md. 4 Donation 5 ☐ Other (Specify) Holly Hill Cem. 8-2-07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Femonit M 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Concarainma & tongue Immediate Cause (Final **Physician** 2 weeks disease or condition resulting in death) /Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>^</u> Hypertecemies Artroiox during Coone 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been ald Coresto smeetan Lecedent 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? dim don Leonore 2 - No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this a after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Milwael

Clustel !

29c. License number D1966)

R. telier Highway \$ 508 Chen Browner, Macyland 21061

29d. Date signed (Month, Day, Year)

and manner stated.

7310 32. Registrar's Signature

San State

2000les 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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AUG 0 2

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 0 2

670: N. Charles ST DWSUN MD 2:204

29d. Date signed (Month, Day, Year)

and manner stated.

WW) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMMES

Arthur Eugene Hoo	1-	For State	tate of M	aryland /		tment of			Menta	al Hyg	iene Reg	No	201	7 2473
Physician/		egistrar Decedent's Name (First, Midd	lle,Last)								Date of Death	Day	Year	Time of Death
Medical Examiner		Arthur E. Hoov	er, Jr	•							Month I July 24, 200)7		1055 hrs
L	4	a. Facility Name (if not instituti 1111 Glenville Road	on, give street	and number)		4	b. City, To Linebo		ocation of	Death		4c. Cou	inty of Death ord	
Funeral	5	. Social Security Number	6. Sex	7. Ag	e (In yrs. las	st birthday)	If Under		If Under	_	8. Date of Birth	(MM/DD/	YYY) 9. Birt Foreig	nplace (State or
Director	1	299-34-0956	1X M 2	F	66	Yrs.	Months	Days	Hours .	Min.	11-10-	1940		ntry) Ohio
acceptation of the second control of the sec	-	Jsual Residence of Decedent			Lio. 64 7	F								10d. Inside City Limits
w and		oa. State 10b. County Maryland Har	ford			Fown or Locati rchvill								1 Yes 2 X No
-f sho		0e. Street and Number			Cira	ICHVIII	10f. Zip (Code			100	a. Citizen	of What Cour	
after death with the Maryland all, or Items 23a or 28a-f show iner must be notified at once. by Funeral Director		1111 Glenville	Rd					028				U.S.		•
with ns 23s	<u> </u>	1. Marital Status		/as Decedent		6. 13. Wa	s Deceden	t of Hisp	anic Origin	n? (Spec	ify Yes or No-		Race - Ameri White, etc.	can Indian, Black,
		1 Never Married 2 1	viairieu		No		Yes 2			,	ouri, o.c.,		cify: Wh:	ite
136 hin 72 hours after e than "natural", edical Examiner	⊊ -	3 Widowed 4 X D 15. Decedent's Education (Sp	Lor.Dat	es:	mpleted)	16a. Deceden	t's Usual C	Occupation	on (Give ki	ind of wor	rk done		of Business/l	ndustry
5-0036 ed within 72 hours lygiene other than "natur he Medical Esam Completed		Elementary/Secondary (0-12		ollege (1-4 or		during m	ost of work	king life. I	DO NOT u	ise retired	d) .			Fare Ar # 10
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2121 Ildibe fi Mental J marked event,		Arthur E. Hoo				19b. Mailine	a Address		Elear		ral Route Numi	per, City o	r Town, State	, Zip Code)
imore, MD 21215-0036 Pages I and 2 shouldbe filed within 72 hours after ment of Health and Myttal Hygield ment and fresh and wheatel Hygield ment and matter it is not it is marked other than "natural", or other traumatic event, the Medical Examiner To Be Completed by I	- 1	Nannette Dieti				1					chvill			
e, N I and I Health item	1	20a. Method of Disposition				Place of Dispos crematory or ot		ne of cerr	netery,		Date	20c. Loca	ation - City or	Town, State
nor ages ont of other		1 Burial 2 X Cremati 4 Donation 5 Other		moval from S	late	view Cr		ory				Balt	imore	Maryland
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is hijury or other traumat		21. Signature of Funeral S				22. 1	Name and	Address	of Facility	Schin	nunek F	unera	al Home	of Bel Air
W FOR	1	Ill the	9			1 11	10. 0	TO M	. ria	-Filai	rr na n	el A.		21014 Approximate Interval
Physician 'Medical	1	23a. Part I. Enter the disease, failure. List only one cause	se on each line).			ne mode o	or ayıng, :	such as ca	ardiac or i	espiratory arre	SI, SHOCK,	or near	Between Onset and Death
aminer		Immediate Cause (Final disea or condition resulting in death		act Gunsh			_		_	_				-
	1	Sequentially list conditions,	b.	(or as a con-	ocquerioe of	.,,.								
i di		if any, leading to immediate		(or as a cons	sequence of	f):								
Bisi & C.		(Disease or injury that initiated events resulting in death) Las	D	(or as a cons	sequence of	f):								
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- a : a :		UNPENDED	AMI	ENDED								1	200	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physical property filled in by the funeral director, page 2 should be deached for use as the butter of the control of the contr		IF FEMALE: 23b. Was decedent pregnant in		Live birth	ome of pregi		etal death	3	Ectopic	pregnan	су		ate of delive onth	y Day Y ear
× 68 th certi		past 12 months?	4		at time of de	oth _	ther (Spec	cify)				į.		
Box le death co	2	1 Yes 2 No 9	3 [Unknown			و من المحادث و		siven in Da	ort I	23e Did to	hacco use	contribute to	the cause of death?
P.O. es that the igned by be detack		Part II. Other significant con	aitions conti	ibuting to dea	ath but not re	esulting in the	underlying	, cause g	giveninira					bably 4 Unknown
duires quires uld be											24a. Was	an		utopsy findings available
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Rec The ficate	5.							OC Diago	e of Death	(Chack o	1 Yes	2 No	1 🗸 \	es 2 No
ician:	m	25. Was case referred to med examiner?	Hospit	al: 1 Innai	tient 2	ER/Outpatier		DOA	Other	-	Home 5	Residenc	e 6 ✔ Oth	er: Scene
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by After this certificate has been signed by fameral director, page 2 should be detached.	<u> </u>	1 ✓ Yes 2 No 27. Manner of Death	2	8a Date of tr	niury	28b. Time of			ıry at Work	?	28d. Describe		occurred	
on on and and and and and and and and and an	틹렱		ending	FOUND: Day		FOUND: 1040 hrs		1	Yes 2 🗸	No S	Subject sho	t sen		
Division tal or Attendir us after death. al Director: A	ertification:		ould not be	28e. Place of	łnjury - At h	ome, farm, str	eet, factory	, office b	building, et		or Town, 9	state)		tural Route Number, City
Dividal of purs all printed in filled in the purs all pur	Cer	4 Homicide	etermined			mily Home					1111 Glenville	e Road, I		
Division To the Hospital or Attend within 24 hours after death. To the Faueral Director: completely filled in by the faueral or the faueral		Condon dray	Physician: 1	o the best of	my knowled	dge, death occ and/or investig	urred at the	e time, d	ate and pla	ace, and o	due to the caus t the time, date	e(s) and and and place	manner as sta , and due to	ated. the cause(s)
To th within To th comp	Medical		and	manne <u>r state</u>					se number					onth, Day, Year)
· ·	2	296. Signature and title of cer	0. 0.	Λ					.M.E.				25, 2007	- '
		30. Name and address of per	son who come	leted sause of	if death (Item	m 23a)								
149		Laron Locke MD.		Medical E		111 Per	n Street	t, Balti	more, N	1D 2120	01			
Sta Registr		31. Date filed (Month, Day, Ye	ar) 2 2007	32 Regis	trar's Signat	ture	2000							
Registr	αľ	ALII2 U	G LUUI	10000000	Allens of									

	•	State Registrar				Cert	tificate of L	Death			Reg. No	.5 116	, 7	21.	135
***	4	1. Decedent's Name (First, Middle	e, Last)							2. Date of De				3. Time of	Death
Physic		JOSEPHINE T. INGL	F							Month JULY 2	Da 7	iy Y 2007	ear	0555	M
/Medi		4a. Facility Name (If not institution		mber)			4b. City, Town, or	Location of	of Death	JOLI 2	-	. County of	Death	0.00.0	
Examir	ıer	8382 BROOKWOOD RD					MILLERS\					ANNE A	RHND	FI	
		5. Social Security Number	6. Sex	7. Age	(In yrs. last birtl	ndav)	If Under 1 Year		24 Hrs.	8. Date of Bir	th	To		ace (State or	Foreign
Funeral		212.26.1120	1 □ M 2\12\1	7		rs.	Months Days	Hours	Min.	(Month, Da AUG. 24	147	8	Coun	try) SYLVANI/	_
Director	ļ	Usual Residence of Decedent			, 0					7100. 219	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
and and		10a. State 10b. County			10c. City, Town	or Loc	ation						1	od. Inside Cit	y Limits
faryl sho	5	MD ANNE	ARUNDEL		MILLES	001/11	15							1 ☐ Yes	2(1) No
the N	Director	10e. Street and Number	ARORDEL		HILLE	3 1 1	10f. Zip Code				10a Ci	tizen of Wh	at Coun	trv2	
d ZIZIS-UU3O filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at													ur Oouri		
s 23	Funeral	8382 BROOKWOOD RD			Turan in III O	40.11		1108	1-0 (0-	'4 · V NI		USA 14. Race -	Amorio	on Indian	
er de tem	I I	11. Marital Status	12. Was Dec	orces?		IS. W	as Decedent of H Yes, specify Cuba	an, Mexicai	n, Puerto	Rican, etc.))-		White,		
s after son in	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	I If Vac G	ive	10	1	□Yes ※X□No	Specify:				Specify:			
5-UUSO 72 hours af natural", or				Jates:							100			ITE	
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ygie dy	S	12			i	RADA	R_TECH	40.14.11		/F:		DEFENCE			
/tand uld be fil Mental H srked oth	Be	17. Father's Name (First, Middle,	Last)							a (First, Middle	, maide	n Surname)			
Men Men atte	၉	JOSEPH SMELIK	_					CATHE	RINE	MAKALA					
Mar nd 2 sho lth and 27 Is ma traums		19a. Informant's Name/Relations	ship (Type. Print)		19b.	Mailing	Address (Street	and Numb	er or Rur	al Route Numb	er, City	or Town, St	ate, Zip	Code)	
alth alth 27.1		JOANN D. KNICHT	DA	UCHT	ER 839	32 BI	ROOKWOOD RI)., HH	LLERS'	VILLE, MO	211	03			
is 1 au of Heal		20a. Method of Disposition			20b. Place of cemeter	Dispos	ition (Name of natory or other plac	ce)	1	Date	20c. L	ocation - Ci	ity or To	wn, State	
Page ent c		1√∑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State	1		CEMETERY	i i	AUG.	1, 2007	GLE	N SURNI	E. M	D.	
DEBITIMOTE, MATYIANG ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Europal Service			\	22.	Name and Addre	ss of Facili	ity				_,		
Dep Dep onc		OF X.C.	1				INK FUNERAL 26 CRAIN HV				Min	21061			
		23a. r a 11. Er er the diseas shock, or heart failure. Lis	complications that	Fillion	the death. Do n							21001		Approximate Interval Bety	,
			t only on - sause on	each lir	10.	0	*		1					Interval Bety Onset and E	veen leath
Physician		Immediate Cause (Final disease or condition resulting in death)	_a/	1/46	elodys!	ela	shic	54	ndr	w					
/Medical Examiner	П	rosaning in accumy	Due to	o (or as	a consequence	f):									
LXammor	l, l	Sequentially list conditions,	b	,		0							_		
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Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit.	Medical		d										_		
ntiffica ng pl	Med	IF FEMALE:											-		
BOX bath ce attendii for use		23b. Was decedent pregnant			pf pregnancy 2 Fetal death	3□	Ectopic pregnancy	v				23d. Date			/
dear deatt	icie	in the past 12 months? 1 ☐ Yes 2 ☑ No		gnant at	time of death		Other (specify)	,				Mont	n	Day Y	'ear
COrds, P.O. BOX or requires that the death certific been signed by the attending p should be detached for use as	Physician	9 Unknown	эшопк	HOWH						-					
s that ned b	by P	Part II. Other significant condit	ions contributing to	death b	ut not resulting in	the un	derlying cause giv	en in Part	l.	23e. Did	tobacco	use contrib	ute to t	ne cause of d	eath?
quire n sig	Q D	Hyper.	tension							1 🗆	Yes	2 No 3	☐ Prob	ably 4 🗆 L	Inknown
W rec	lete	/								24a. Wa:	s an	24b. W	ere auto	psy findings	available
VITAI HECOTGS, stclan: The law requires t certificate has been signe irector, page 2 should be o	Completed			-						auto	opsy formed2	/ de	ath?	psy findings a mpletion of ca	ause of
- 10										1□ Yes	2 🗷 N	lo 1 [∃Yes	2 No	pd.
Or VITA Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Oth	OF.		th (Check only					
	2	1 ☐ Yes 2 ₺ No	_ · · · · · · · · · · · · · · · · · ·	Inpatie		<u> </u>	1 3 DOA	4 LJ N	ursing Ho	ome 5 Res				ty)	
DIVISION OF it or Attending Physical death. I Director: After this d in by the funeral di	Certification:	27. Manner of Death 1 ■ Natural 5 □ Pendi	ng .			ime of njury	28c. Injur			28d. Describe	now inj	ury occurred	a		
SIO tendi eath.	cati	Z L Accident	tigation					Yes 2	No						
rati	Ħ	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined 200. Flat	ce of inj ding, et	ury - At home, fai c. <i>(Specify)</i>	rm, stre	eet, factory, office			28f. Location City or To	(Street a own, Sta	and Number ite)	or Rura	al Route Num	ber,
DIVISION OF To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this Completely filled in by the funeral director.	Ce														
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To t To t	Σ	29b. Signature and title of certifi	er				29c. Licens	se number				ate signed		- /	
, <1		1 Cp	1/192	-				256	54	1	1	LLT .	27	200	7
12		30. Name and address of person	n who completed ca	use of c	leath (Item 23a) (Type, I	Print)		, -						
U		YEUNG DE		12	NIL	VA	in the	6	3 B	, w	10	2	100	5 1	
St	ate	31. Date filed (Month, Day, Year	r) 32	Registr	ar's Signature										
Regist		AUG 0.2	2007		20	A. a.	1.00								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

ORIGINAL

		4	For State	State of Maryland		rtment of H <i>tificate of L</i>			1 12		0170
			Registrar		Cer	uncate of L	Jeaui ———————	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia	_	Decedent's Name (First, Middle, Last)					Month	Day	Year	10:32 A. ^M
	/Medic	al	OKEL JOHNSON 4a. Facility Name (If not institution, give s	troot and number)		4b. City, Town, or	Location of Death	JULY 2	-	y of Death	10:32 A.
	Examin	er		reet and number)		GLEN BUF			ANNE	ARUN	DEL
	Funeral		418 ARBOR DR. 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birti (Month, Day			lace (State or Foreign
	Funeral Director			M 2□F 84	Yrs.	Months Days	Hours Min.	NOV. 3		WEST	VIRGINIA
	D	ļ	Usual Residence of Decedent			-41				1	0d. Inside City Limits
	inylan ihow	_	10a. State 10b. County	10c. City	, Town or Lo	auon					1 ☐ Yes 2 ☑ No
:	ne Ma 8a-f s stiffie	Director	MARYLAND ANNE ARU	NDEL GL	EN BUR	NIE 10f. Zip Code	<u></u> .		10g. Citizen of	What Cour	
:	vith th	ä	10e. Street and Number						UNITED		
	sath v s 23g nust	Funeral	418 ARBOR DR.	12. Was Decedent Ever in U.	S. 13. V	21061 Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sr	pecify Yes or No		ce - Americ	can Indian,
	ter de item	Ľ.	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🕱 No				o Rican, etc.)		ack, White,	etc.
0000	ırs af	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I∐Yes 2∏No	Specify:		Speci	-	HITE
ž	2 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	ation during most of worl	king I	16b. Kind of E	Business/In	dustry
7	thin 7 e. an "r Med	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done o)				
7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	4		CRAI	NE OPERAT	OR 18. Mother's Nam	on (First Middle	CHEMIC		MPANY
ana	be file tal Hy d oth even	Be	17. Father's Name (First, Middle, Last)					UTSINGE!		inej	
Z Z	should b and Ment s marked umatic e	2	PERRY V. JOHNSON	- O Print\	10h Mailin	ig Address (Street				n. State. Zit	Code)
Mar	12sh hand 7ism traum	ĺ	19a. Informant's Name/Relationship (Ty)			ARBOR DR.		BURNIE,		061	
<u>မ</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		HELEN J. JOHNSON 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	1	Date	20c. Location		own, State
altimor	ages ant of tt: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Denation 5 ☐ Other (Specify)	lemoval from State		EN MEM. F	11000	ST 1,	CLEN BI	IRNTE	MARYLAND
	nit. Fartmontar ortar Injur		21. Signature of Foregral Service License		22	. Name and Addre	ss of Facility				
ñ	Per any any any any		1 tello/m	\	4	IRKLEY-RU 21 CRAIN	HWY. SE;	GLEN	BURNIE,	MD 2	1061
E	**************************************		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	h. Do not ent	er the mode of dyir	ig, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	lung	C	nuces	_				[WX
A	/Medical		resulting in death)	Due to (or as a co	uence of):						
	Examiner		Sequentially list conditions,	Due to (or as a conseq	nence of).						
_	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or hijory that initiated events	D 40 to (or 40 a conseq							
$\tilde{\gamma}_{ m b}$	execunate and al-train	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
8760,4	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d							
9	tificat ng phy as th	ledi	is setting	-							
. Box	eath certifi attending p for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnanc	y			Date of delivery of the Date o	very Day Year
). E	e dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	death 5[Other (specify) _					
<u>о</u>	res that the de signed by the a be detached t	Phy	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?
Vital Records,	ires the signe	þ	Tarin only digimount sensitives	g	· ·			172	ves 2 □ No	3 ☐ Pro	bably 4 Unknown
Ö	w require been sig should b	Completed						24a. Was	an 24	b. Were au	topsy findings available
E E	he lav	ш				* 4000			opsy ormed?	prior to c death?	ompletion of cause of 2□ No
a	ician: Th certificate ector, pag		25. Was case referred to medical				26 Place of De	ath Check onl	2 X No ∣ one	1 ∐ Yes	2L] NO
5	s cert lirect	o Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	nt 3□ DOA Oth	201	lome 5 ☑ Res		Other (Spec	sify)
Ö	g Physer this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju	ry at rk?	28d. Describe	how injury occ	curred	
<u>0</u>	ath. or: Aft	atio	1 Natural 5 Pending investigation]Yes 2□No				
Division or	r Atte er de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, st ify)	reet, factory, office		28f. Location City or To	(Street and Nui own, State)	mber or Ru	ral Route Number,
	oital o urs aft eral D		an Outilian Bhu	vsician: To the best of my kn	oulodgo dea	th occurred at the t	ime date and plac	e and due to the	e cause(s) and	manner as	stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	29a. Certifier 1 🔀 Certifying Phy (Check only one) 2 🗆 Medical Exam	iner: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death occ	urred at the time	e, date and place	ce, and due	to the cause(s)
	Fo the vithin Fo the comple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date sig	ned (Mont)	n, Day, Year)
	->-0		Manh	ay M-D		D39	505		JULY :	27, 20	007
	0		30. Name and address of person who o	ompleted cause of death (Ite	m 23a) (Type						
_	10		DR. YUDHISHTRA MA			SPITAL D	R.; GLE	N BURNIE	E, MD 2	1061	
		oto	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature 🥒						

Registrar

AUG 0 2 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc 88/0 8-7-07 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Doris L. Month Year **Physician** 30 2007 00 ame /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner neverlu trinee Occopes ommunital tospital Hours Min. 8. Date of Birth (Month, Day, If Under 1 Year State or Foreign 9. Birthplace (Country) 6/Sex 7. Age (Id yrs. last birthday) 5. Social Security Number **Funeral** Days 77-05-4641 1 ☐ M 2 1 F Virginia Director June Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Yes 2 No 1)(Nashina Completed by Funeral Director ton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 20019 states)nuted 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Tes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DERVISOR Administration Veteraus 18 Mother's Name, (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be varlotte 105/el truanes DEED ဨ 19b. Mailing Address (Street and Number or Rural Route Number, 1367 Christle Pace VPPEK Hakl City or Town, State, Zip Code) 19a. Informa 's Name/Relatio hip (Type, Print) 13107 Christie Maxlboro MD 20774 Denjamin James 201 20b. Place of Disposition (Name of cemetery, crelinatory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation
4 Donation 5 Other (S 3 Removal from State 2007 Department of important: If sny injury or ponce. 6 andover Harmon 5 Other (Specify) John T. Klunes tuneval Home 22. Name and Address of Facility 21. Sonature of Funeral Service L 03 20011 ot. huntar omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause an each line. Approximate Interval Between Onset and Death 23a, Part . Enter ! e diseas shock, or h art fail Immediate Cayse (Final disease or condition resulting in death) DEPSIS Physician /Medical Due to (on as a consequence of): Examiner Cloma etastatic utticle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death the detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 1 🗀 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 1 Yes 2 No the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? r? 2**X** № Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA his 27. Manner of D 28a. Dite of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31 D47604 12007 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD 3048 Mitchellville Mathew Howie. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 2 2007 Registrar ORALE D

DHMH 17 Rev 1/2001

ORIGINA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#7 perFH G870 8/7/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Robert M. Kuhn 6 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Memorial Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 02 (Mornth, Day Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral 1**X** M 2□ F Months Pennsylvania 218-18-9990 Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Maryland Harford Aberdeen Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 "natural", or items 23a or dlcal Examiner must be U.S.A.
14. Race - American Indian, 4808 Mantlewood Way 21001 Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White \$ 3 Widowed 4 Divorced than "natura", the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Policeman Baltimore City 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even David Kuhn Olive Herring 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Kuhn (Wife) 4808 Mantlewood Way Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Holly Hill Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 7-30-2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Q 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) by the a 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy certificate ha 1□ Yes 2▼No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28b. Time of Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 27860 1211 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) BATTOND 21218 CHRISTOPHER EARNEY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

ms 23a or 28a-f show must be notified at

"natural", or items

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Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, If once.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Re Completed by Dhysician/Medical in by the funeral after death. within 24 hours aft To the Funeral Di completely filled in

29b. Signature and title of gertifier

30. Name and address of person

31. Date filed (Month, Day, Year)

STUART

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

4 □ Donation 5 □ Other (Specify)	Mar	yland Vete	rans	72007	OMIIZATTI	e rib
21. Signatur et neral Beryton 103	M01364			ingleton Fu len Burnie		
23a. Part . Enter the disease, or complishock, or heart failure. List only or	ications that caused the death ne cause on each line.	. Do not enter the mod	le of dying, such as card	iac or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		cisptanmen				2 hours
	Due to (or as a consequ	ence of):	preumon	14		lday
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Carcinom4 Due to (or as a consequence)		ig-metasta	tic		11 4295
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pregn <i>a</i> r 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □ Ectopic p			23d. Date of de Month	elivery Day Year
Part II. Other significant conditions col	ntributing to death but not resu	Iting in the underlying o	cause given in Part I.			o the cause of death? Probably 4 Unknown
				24a. Was an autopsy performed 1 Yes 2 ✓	death?	nutopsy findings available completion of cause of s
25. Was case referred to medical	,		26. Place of D	leath (Check only one)		
examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ E	ER/Outpatient 3 De	OA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Spe	ecify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1	28d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hos building, etc. (Specify	me, farm, street, factor	y, office	28f. Location (Street City or Town, St	and Number or Flate)	Rural Route Number,
	sician: To the best of my know iner: On the basis of examinat and manner stated.					
29b. Signature and title of dertifier		29	c. License number	29d.	Date signed (Mon	ith, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Nospital

pleted cause of death (Item 23a) (Type, Print)

♣2. Registrar's Signature

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Dr. Glen Burne, mp 2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JULY 30,2007 PATRICIA CAMP LANG 3:45 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death JOSEPH RICHEY HOSPICE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year JULY 25, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) Months 1950 NEW JERSEY 1 □ M 2 X F 136-46-5983 57 Yrs. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE PARKTON 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17912 YORK ROAD 21120 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify: WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM CAMP LOUISE VEZZITTI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $17912\ YORK\ RD \bullet\ PARKTON$, MD 2112019a. Informant's Name/Relationship (Type. Print) CHRIS LANG husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State GREEN MOUNT 2007 BALTIMORE, MD AUG 1, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W . 21. Signature of Funeral Service Licensee JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD 0N822) Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) omo Due to (or as consequence of): Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Hothelle John Went 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

2/4 P.O. Box 68760 30/0 Division or Vital Records,

as signed by the attending the detached for use as page 2 s has certificate filled in by the funeral director, within 24 hours after death.

To the Funeral Director: / To the Hospital

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural", or

It of Health and Mental Hygiene. If Item 27 Is marked other than or other traumatic event, the Me

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.

Physician

/Medical

Examiner

ould be filed within 72 hours after Mental Hygiene.

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

25. Was case referred to medical examiner?

4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

2 2007

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Mgnth, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) 630/ N. Charles Street, Bultmers MD 21212

III MD

31. Date filed (Month, Day, Year) State AUG 0 Registrar

29a. Certifier

32 Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30 HARRY 2007 LEVIN /Medical 4a. Facility Name (If not institution, give street and numb **Examiner** Baltimore timore 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months 10//13/1918 Country MD 88 213-09-584 Director Usual Residence of Decedent death with the Maryland 10c. Cify, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f shormust be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 POMONA EAST APT. #105 21208 U.S.A. Funeral Item 27 Is marked other than "natural", or Items other traumatic event, the Medical Examiner man 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 MYes 2 No WW II If Wes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) PRINCIPAL EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEVIN SAMUEL LENA KANOWSKY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCINE FRIEDMAN / DAUGHTER 556 LONGHORN CRESCENT - ROCKVILLE, MD 20850 20b. Place of Disposition (Name of ANSADE MAIN CONG. 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/01/2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. B900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Willer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify). been signed by the sales should be detached to 1 □ Yes 2 □ No 9□Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown enacotive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 Yes 21 No 27. Manner of lea 1 Natural 5 2 Accident 1 npatient Other: 4 Nursing Home Hospital: ၉ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Leadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name and address of person who

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31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Sinai Hospital of Baltimo

State Registrar Mock

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Young McKoy July 25 2007 9:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 136 New Mark Esplanade Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 10,1941 Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🖫 F Hours Min. 65 Director 579-54-3549 Washington D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Rockville Montgomery 1 □ Yes 24 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō Examiner must be 136 New Mark Esplanade 20850 United States 23a Funeral or items, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 f Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 ☐ Widowed 4 🔀 Divorced White 'naturai", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4or 5+) Elementary/Secondary (0-12) Administrator Health Care permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: if item 27 is marked other any injury or other traumatic event, tit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samue1 Young Margaret Ε. Eppler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward McKoy / Son 136 New Mark Esplanade, Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 27, '07 Sciencecare Aurora, Colorado 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 21. Signature of Funeral Service License MO0382 tepler Johnson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical phys. the b attending ph IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe performed? 1□ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Susan Stinson M.D. 31. Date filed (Month, Par. Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6420 Rockledge Dr. Suite #1200, Bethesda, MD 32/Registrar's Signature

034840

July 27, 2007

20817

SAID TO BE: MARILYN MEYER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 20a, perFH,C870, 8/2/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MEYER MARILYN 0530 AM Darbara 40 30/2007 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Road Baltimore Suite 503 WD Saltimate Cois IIIHAMLET If Unde 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🗹 F Months Days Min. 397 24 60 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show rral", or Items 23a or 28a-f shov Examiner must be notified at 1 ¥Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant If Item 27 Is marked other than "natural", or Items 23a or ury or other traumatic event, the Medical Examiner must be a 111 HAMLET HILL ROAD #503 21210 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Saltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FITNESS INSTRUCTOR FITNESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY BAYLINSON FRANCES MARGOLIN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN MEYER / SON 1655 BULLOCK CIRCLE - OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of HIMPortant: If Ite any Injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CONG; 08/01/2007 REISTERSTOWN, MD n 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Ligensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** tarkinson years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has t autopsy performe certificate 1∐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 nesidence 7 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) Atter this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ∏Yes 2 ∏No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide the Hospital 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7/30/07 16755 Falls Row Sule 200 Lutlarulle MD 21093 30. Na usu address of p wothu 31. Date filed (Month, Day Year) 32. Registrar's Signature State AUG 0 200 Registrar Care.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 28, 2007 July 11 P M Joseph Martin Prince, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Health and Rehabilitation Glen Burnie Anne Arundel Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 215-40-2734 1 M 2 □ F 63 MaryTand July 2, 1944 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 X Yes 2 ☐ No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2024 Griffis Avenue 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver J.P. Foods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Joseph Prince Mary Ellen Dix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle F. Prince/Wife 2024 Griffis Avenue Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State West Arundel Crematory 8-2-2007 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Odenton, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) coolina /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if no cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical as attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown certificate has been signed by rector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? underlying cause given in PartT Division or Vital Records. Completed by 1 ☐ Yes 2 No 3 Probably ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 21 No To the Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 ₩ Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury n 24 hours after death.

In Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 24 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year)

57

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
AUG 0 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 7 30 Day 2007 8:45 P M DONALD ROWLAND RUSSELL 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 420 Burwood Avenue Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1₩ 2□F 238-10-4110 95 5/6/1912 NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 420 Burwood Avenue 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No white Specify. Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transit Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Parks Russell Della Mae Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Hillcrest Dr., Hanover, PA Mrs. Shirley M. Snyder/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/3/2007 Glen Burnie Glen Haven Cemetery 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Sign The Life neral Service Line ases 1 Second Ave SW M01364 Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 1 ☐ Yes 2 □ No 24a. Was an

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or ot

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with thent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or?
ury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

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the Maryland

attending physician and for use as the burial-transi been signed by the should be detached has page 2 funeral director, this

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital

within 24 hours after death. To the Funeral Director: /

the

in by t

completely

Medical

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical 2 Completed Be 2 Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

> autopsy performe 2 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to-medical 1 Tes 2 No 27. Manner of Death

1 Natural

2 ☐ Accident

3☐ Suicide

29a. Certifier

4 ☐ Homicide

5 ☐ Pending investigation 6 Could not be determined

28a. Date of Injury 28b. Time of Injury (Month, Ďay Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

1 | Inpatient

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatu and title of certifig

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year) cans there Willers We MD 2/108

32. Registrar's Signature

State Registrar

atricia Noel Re		ne St 1- For State Registrar	ate of Maryl			ment of ficate of			Menta	al Hy		g. No.		7 24.74	
Physicia	ın/	Decedent's Name (First, Middle)	le,Last)							T	2. Date of Death	1		3. Time of Death	
ledical Exami	ner	Noel Patri		kline							Month July 30, 20	Day Year		1743 hrs	
		4a. Facility Name (if not institution 1206 Independence S	-	umber)		41	o. City, T Belca	Fown, or Lo I mp	ocation of	Death		4c. County o Harford	f Death		
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last	birthday)	If Unde	er 1 Year	If Under	24Hrs.	8. Date of Birth	h(MM/DD/YYYY)	9. Birth	place (State or	
Director		217-58-1048	1M_2X_F	55	5	Yrs.	Month	s Days	Hours	Min.	Oct. 2	2,1951	Foreign Cour	Maryland	
		Usual Residence of Decedent		1											
ow any		10a. State 10b. County	c 1	10c.	. City, 10	own or Location		-						1 Od. Inside City Limits 1 Yes 2 X No	
th the Maryland 23a or 28a-f show	ctor	Maryland H	arford				Be 10f. Zip	21cam	p		10	g. Citizen of Wh	L		
he Ma or 28	Director		Ca					2101	7						
with t		1206 Independe	12. Was De	cedent Eve	r in U.S.			nt of Hisp	anic Origi		ecify Yes or No-	14. Race		en Indian, Black,	
death	Funeral	1 Never Married 2 M	arried Armed F	orces?	No	If Ye	s, specif	fy Cuban,	Mexican,	Puerto I	Rican, etc.)	White	, etc.		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examilier must be notified at once	by F		orced If Yes, Give Ye					X No				Specify:		ite	
2 hours:	ted	 Decedent's Education (Spe Elementary/Secondary (0-12) 		1-4 or 5+)	ed) 1	6a. Decedent during mo						16b. Kind of Bus	iness/In	dustry	
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121 J be fil ental H arked	Be	Melvin Dembeck								Anna Grubowski ber or Rural Route Number, City or Town, State, Zip Code) 21220					
MD 21 d 2 should be th and Mer n 27 is mar sumatic eve	٩	19a. Informant's Name/Relations													
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altin mit. P partme sortan	119	4 Donation 5 Other Si 21. Signature of Funeral Service		l.	ьау	view Ci	ame and	Address	of Facility	Sch	imunak	Funeral	Hom.	Maryland	
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Physician Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the	death. D	o not enter the	e mode	of dying, s	uch as ca	rdiac or	respiratory arre	est, shock, or hea	ırt	Approximate Interval Between Onset and	
aminer		Immediate Cause (Final disease or condition resulting in death)				ardiovas	cular	r dise	ase					Death	
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Box 68760 e death certificate E the attending physical of for use as the bu	ian/Me	IF FEMALE: 23b. Was decedent pregnant in t	23C. II yes	, outcome o	f pregna	incy	al death		Ectopic	pregnai	ncv	23d. Date of Month	delivery Da	ay Year	
th cert	ပ	past 12 months?	4 Preg	nant at time	of deat	, - H	ier (Spe	-						.,	
. BO) the deatl y the att	Physi	Part II. Other significant condit	9 Uliki	nown	1 201 700	ulting in the	a dadi da	2 201100 01	on in Dar	- 1	23e Did to	hacco use contr	hute to t	ne cause of death?	
Division of Vital Records, P.O. Box 68760 and the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	ρ	Fait II. Other significant condi-	dons contributing	to death but	t not res	uning in the u	ndenying	g cause gr	ven in Fai	11.				ably 4 V Unknown	
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	edical		aminer: On the basis	of examina											
F * F 8	Me	29b. Signature and title of certific					29	c. License			-	29d. Date sign		th, Day, Year)	
2 2		Theodore 1	U. Kys	TR	1.	no		O.C.N	1.E.	OCM	E	July 31, 20	07		
Oxberg		30. Name and address of person Theodore M. King, Jr.		use of death ant Medi			111 P	enn Stra	eet Bal	timore	e, MD 21201				
	ate	31. Date filed (Month, Day, Year)	32 F	Registrar's S				- Out	Jor, Dai		,, IVID 2 12 U I	•			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Q" 2007 1620 29 Gerald Warren Raspe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F Yrs Maryland Feb. 1944 63 Director 219-42-6566 Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2X No 28a-f sh notified Director Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 21085 U. S. A. 124 Philadelphia Road death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Heavy Equipment Company 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Austin William Raspe Eleanor Elizabeth Petry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if Item 27 is any injury or other trau 124 Philadelphia Road, Joppa, Maryland 21085 Mary E. Raspe (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 08/03/2007 | Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licenses 9705 Belair Road, Baltimore, Maryland 21236 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DECas eav 5 Physician ononari /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ası IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown has been signed as 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy certificate ha performed 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Z aturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State Registrar

(9)

29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month, Day,

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SAMEN MITEMAND DEPRITENT GP70 alin 160 MeWal Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year KONNY I=RS 23 ,2007 0625A-4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hospital
7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Alt, MORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)_ 8. Date of Birth (Month, Day, Year) Months 1**X**M 2□ F 217-90-9960 South (Usual Residence of Decedent 10c. City, Town or Location Baltimore 10d. Inside City Limits 10b. County 1 XYes PINO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Abbott Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Apartment aintanence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) brothea 433 Guynn Cak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1 E. 01.4ER ST BA 140 M& 21. Name and Address of Facility 24 2/2/3 ESPA A WEATHER LORS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Due to for as a consequence of). Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Completed

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Certification:

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within 24 hours a To the Funeral I

Hospital or Attending

To the

Physician

/Medical

Examiner

10a. State

Director

by Funeral

Completed

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat, or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Extra are miss be notified at any injury or other traumatic event, I'm Medical Extra are miss be notified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 7 Unknown

26. Place of Death (Check only one)

24a. Was an autopsy performe 2/C No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣ No

25. Was case referred to medical examiner? Yes 2 No 27. Magner of Death Natural 2 Accident

3 🗀 Suicide

4 Homicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DQA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

5 Pending

investigation 6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

KALATHIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 0018230

26

State Registrar

31. Date filed (Month, Day, Year) AUG 0 2 2007

SHASH DHARAN 32 signature

5601 Loch Raven Bowlevard, MD 31239

			1 - For State Registrar	State of	f Marylan		artment tificate			and M	ental Hygi	iene	07	24751	
	51	1. Decedent's Name (First, Middle, L						2. Date of Death Month Day		Year	3. Time of Death				
	Physici /Medic		Stella E. Sidlik								July 20, 2007			7:50 PM M	
	Examin		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death					4c. County of Death			
			3032 Parktowne				Ba If Under	ltim		24 Hrs T	0 D / B'.th	Ва	ltimo		
	Funeral		5. Social Security Number 6. 214–20–8933	Sex 1 □ M 2 🛱 F	7. Age (In yrs. 81	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, May 10,	1926	Mary	pplace (State or Foreign Intry) 'Land	
	Director		Usual Residence of Decedent		01						ilay 10,	1,20	III. J	20110	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	Mar.	io	MD Baltimo	re	Ва	1timor	e							1 ☐ Yes 2X No	
	or 28	Directo	10e. Street and Number					10f. Zip Code				og. Citizen of	What Cou	untry?	
	ath w 23a		3032 Parktowne Road				21234					USA			
	er de	Funeral	11. Marital Status	Armed Fo		.S. 13. \	Was Deced 1 Yes, spec	ent of Hi rfy Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		ce - Amer ack, White	ican Indian, , etc.	
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7.7	d with	To Be Completed	8	0	-401 3+)	hou	sewif	e				own h	ome_		
Maryland 21215-0036	e filed al Hygie other		17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	(First, Middle, A	Aaiden Suma	me)		
<u>a</u>	should be ind Mental I		Anthony Sobul						Ber	tha	Bielik				
E .	0. 0		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	or Or Rura	l Route Number,	City or Town	n, State, Z	ip Code)	
	1 end 2 Health tem 27 i		Raymond J. Sidli	k/spouse					Road		Ltimore,		1234		
9	permit. Pages 1 e Department of Hee Important: if Item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from	1 ~	Place of Dispo semetery, crer	isition (Nan natory or o	ne of ther place	θ)	L	ate 2	20c. Location	- City or 1	Town, State	
Ē			4 \notin 5 \notin Other (Spec		71				1						
Baltimore,			21. Sign up of Funeral Service Lic	Wad I	rector	St	Name and ate A litimo	Inato	omy Bo	oard 21201	655 W.	Baltim	ore	Street	
	Physician /Medical Examiner		23a. Part1 Enter the disease, or co shock, or heart failure. List on	mplications that c	aused the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between	
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XOR	eath certific attending pl	/W	IF FEMALE: 23b. Was decedent pregnant		come of pregna						23d. Dat		ate ol deli	ol delivery	
ň	death e atte d for	ed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No		Ectopic pregnancy 				Month		Day Year				
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Ĭ	The ate h page	Completed									perfore	ned? ⊇ No	death?	2□ No	
Vital H	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only on	e)			
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Ē		iuo	27. Manner of Death 1 ☐Natural 5 ☐ Pending		ol Injury th, Day Year)	28b. Time of 28c. Injury at Work?					28d. Describe how injury occurred				
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Division		Certification:	4 ☐ Homicide determine	289. Place	286. Place of injury - At nome, farm, street, factory, office							cation (Street and Number or Rural Route Number, ity or Town, State)			
		edicai	29a. Certifier (Chack only one) 1. Certifying Physician: T, the best of my in: wedge death occurred at the time date and clade, and due to the cause(s) and menner as stated 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To the within To the Comp	Me	29b. Signature and title of certifier	0	VA	1	290	. License	number		2	9d. Date sign	ed (Monti	n, Day, Year)	
)	_		Lamen	e /	2 / Filler m 1) 00 30/2 2							7-25-07			
			30. Name and address of person wh	o completed caus	se of death (Item	n 23a) (Type,	Print)	-	nd.		241				
			7505 Osler	Drive	508		vson,	, 1	nd.	717	04				
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4	Regist	ar	AUG 0	Z LUUV	A MARKED	15.	HEALE	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 1:25 P.M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Maryland Hospital Douthern trince beardes linton 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 224-407017 walnice Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Sevals Yes 2 No Director er ince 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 2300 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after nand Mental Hygiene.

Is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
(ije. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) County College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) Father's Name_(First, Middle, Last, oknine - reen 19a. Informant's Name/Relationship (Tyge. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum Hills laughter 2300 HA ton It 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from Kwerdale Crematori kiverdale Havilland 4 Donation 5 ☐ Other (Specify) Funeral Home Khines 22. Name and Address of Facility Signature John NE Washington Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Advanual Canin Unkno. disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43446 7.27 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 George Ave Sit 3-41 Silon spin FARAHIFAR MID ROINTAN

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG 0 2 2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JUNE SPENCER JULY 24 2007 3:15 A /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD 8. Date of Birth (Month, Day, Year) June 19, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 ☐ M 2 👿 F Maryland June 1928 79 Director 220-20-1297 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Examinar must han account. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Directo Glen Arm Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21057 P O Box 5021 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2**X** No Specify: Specify: þ White Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Company Receptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Henry Frederick C. Fischbach 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P<u>O Box 5021</u>, Glen Arm, Maryland 21057 Harold W. Spencer (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 07/27/2007 Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licenses 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) peritone Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To

Physician /Medical Examiner The law requires that the death certificate be executed and burial-tra Division or Vital Records, P.O. Box 68760, attending physician

Saltimore, Maryland 21215-0036

as the b signed by to detach. 2 should page funeral director, filled in by

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After

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within 24 hours after death To the Funeral Director:

completely

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or Attending Physician:

Hospital

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

28d. Describe how injury occurred 28c. Injury at Work? 1 TYes 2 TNo 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

AUG 0 2

4 Homicide

(Check only

31. Date filed (Month, Day, Year)

29a, Certifier

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29c. License number

29d. Date signed (Month, Day, Year) 200 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014 DR. DAVID

and manner stated.

Registrar

ennis Henry Sเ			ate of Maryl	and / Dep	artment o	of Healt	h and						117	2475
		Registrar	1-10	Ce	rtificate d	of Deatr	7		10.	Reg Date of Death	. No.	Bay Suil		me of Death
Physicia ledical Exami		Decedent's Name (First, Midd Dennis Henry)	Sulkowski						j J	vonth Uly 28, 20	Day 07	Year	1	720 hrs
		4a. Facility Name (if not institution 31 Perry Falls Road	on, give street and n	umber)		4b. City, To Parkvi		ocation of I	Death			ounty of Detimore C		
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D 21 should and Mei ' is mai	ဥ	9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 1224 Rolling Knoll Dr. Bel Air, MD 21014										Code)		
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			For State Registrar	State of Maryla		rtificate of			eg. No.	64100
	Physici	an	Decedent's Name (First, Middle, Last, Barbara Jean I		h			2. Date of Deat Month	Day Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give			4h City Town or	Location of Deat	July 29	2007 4c. County of De	8:40 aм
	Examin	er	Washington Advent		1		a Park			gomery
	Funeral Director		072-32-2130	7. Age (In y	rs. last birthday Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, March 5,	Year) (rthplace (State or Foreign Country) WV
	faryland ehow	٥	Usual Residence of Decedent 10a, State		City, Town or L	ocation Welc	h			10d. Inside City Limits 1 XYes 2 No
	with the A 3a or 28a-	i Director	10e. Street and Number 318 Court Street	et		10f. Zip Code	801	1	0g. Citizen of What 0	Country?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel; or items 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No		Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify:	
Maryland 21215-0036	within 72 ho ene. then "natui he Medical	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired lead Start	during most of wo d)	rking		s/Industry Of Southern tains
and 2	ould be filed within Mental Hygiene. arked other then ' atic event, the Me	To Be Co	12 17. Father's Name (First, Middle, Last) Robert A. Hewit	t Jr.	1.	ead Start	18. Mother's Na	me (First, Middle, M	Maiden Surname)	
	and 2 should be lealth and Mental m 27 is marked (her traumatic ev	F	19a. Informant's Name/Relationship (Ty Vanessa Robertson	pe, Print) 1 / Daughter	19b. Mai 541	ing Address (Street 4 14th.	and Number or Ri Place, F	ural Route Number Tyattsvil	City or Town, State	Zip Code) 782
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, cre	osition (Name of ematory or other place Mausoleu	m Augus		20c. Location - City of Bluewell	
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8.5°	Physician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.		nter the mode of dyin			est,	Approximate Interval Between Onset and Death
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	To the Hospitel or Atter within 24 hours after de To the Funerel Directo completely filled in by th	Medical (sician: To the best of my ner: On the basis of exam and manner stated.				urred at the time, d	ate and place, and d	ue to the cause(s)
	To t To t	×	29b. Signature and title of certifier	MD		29c. Licens	se number		9d. Date signed (Mo	
	6		30. Name and address of person who c	empleted cause of death (Item 23a) (Type	AAPOV	GR PAR	KWAY	GREETE	2007 BELT MARILANA
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 2 200	32cRegistrar's S		ww				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ANITA SCHEUERMAN JULY 30, 2007 10:08 A.M L. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1303 CROWNFIELD COURT TOWSON 1 Year If Under 24 Hrs. BALTIMORE Social Security Number 7. Age (In vrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗙 F 212-10-9428 Director 8/25/1917 89 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD BALTIMORE TOWSON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 1303 CROWNFIELD COURT 21239 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASST. BRANCH MANAGER BANKING 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES GRAF MARIE SCHAEFER မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER E. MCMAHAN/GREAT NIECE 310 FOX HOUND COURT BEL AIR, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/3/07 BALTIMORE, MD MOST HOLY REDEEMER CEM. 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) MICCARDIA Physician /Medical Due to (or as a consequence of): Examiner 40tivension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner HYDERLIPIDEMIA To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and 4cars Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2**24**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 AResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

10

31. Date filed (Month, Day, Year) State

30. Name and addres

29b. Signature and

title of certifier

DR OSLER 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 29c. License number

UCOIL

MOSOM

James Kleeman,

MI

MD

21204

29d. Date signed (Month, Day, Year)

	Please Type or Print in Black			
	_ FOT	epartment of Health and M Certificate of Death	Reg. No. 200	7 24.75
Physician /Medical	Decedent's Name (First, Middle, Last) Raphael Walter Skutch		2. Date of Death 1011y 29 ay 2007	3. Time of Death 9:00 P.M
Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) Brighton Gardens 5. Social Security Number 218-03-9308	Months Days Hours Min.	(Month, Day, Year)	
-f show ied at tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Decedent 10a. State 10b. County Pikes	or Location SVIlle		10d. Inside City Limits 1 ☐ Yes 2 No
permit. Fages 1 and 2 should be flied within 2 hours arer death with the maryland Department of Health and Mental Hygiene. Important: If fire It is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 801 Olmstead Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 21208 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	United States ecify Yes or No- Rican, etc.) 10g. Citizen of What C	of America
atural", or its	Wildowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: V	Thite
ygiene. ner than "natur; tt, the Medical E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 O	Give kind of work done during most of work ite. DO NOT use retired tructural Engineer	Steel Erec	tion
Mental H arked ott atic even To Be	17. Father's Name (First, Middle, Last) Robert Frank Skutch	Rache1	e (First, Middle, Maiden Surname) Frank Skutch	
n 27 is m	19a. Informant's Name/Relationship (Type. Print) Melissa Park (Daughter) 4221	Mailing Address (Street and Number or Run Lestview Road, Bal	timore, Maryland	21218
Department of Hi Important: If iter any Injury or oth once.	1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State cemetery,	crematory or other place)	ing Byers Funeral	e, MD. 21228 Directors,
as been signed by the attending physician and 2 should be detached for use as the burial-transit u polymerical and a polymerical examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)			Months
been signed by the attending physician and should be detached for use as the burial-transit letted by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	elivery Day Year
n signed by	Part II. Other significant conditions contributing to death but not resulting in a	he underlying cause given in Part I.	23e. Did tobacco use contribute 1	to the cause of death? Probably 4 □Unknow
icate has been s r, page 2 should Completed			autopsy prior to death? 1 Yes 2 No 1 Yes	
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compl	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	atient 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 ☐ Residence 6 ☐ Other (Sp. 28d. Describe how injury occurred	pocify) Aighted li Vie Facility
nours after death. neral Director: After filled in by the funer. al Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify) 29a. Certifier 29a. Certifier	death occurred at the time, date and place,		as stated.
within 24 hou To the Fune completely fi	(Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
12	30. Name and address of person who completed cause of death (Item 23a) (T	des It towning	21204	
State Registrar	31. Date filed (Month, Day, Year) AUG 0 2 2007 32. Redistrar's Signature	Spark		

1-

Physician

/Medical

Examiner

Director

Completed by Funeral

Be 2

Examiner

Physician/Medical

Completed by

Medical Certification: To Be

Funeral

	Pleas	e Type or P							I Copies A		egible.		
For State Registrar		State of	iviai yiai i		rtificate			iliu iv		. No. 🥬		21	753
1. Decedent's Nam	e (First, Middle,	Last)							Date of Death Month	Day	Year	3. Time	of Death
Anthony	Erie Sm	ith								23	2007	6:5	5 a ^M
		give street and numb	er)		4b. City,	Town, or	Location of	f Death		4c. Co	unty of Deat	h	
Casey Ho					Roc1	kvi1	1e If Under 2	24 Um	0 D-1(Di-1	Mon	tgomen		
5. Social Security N 220–62–54		5. Sex 7	Age (In yrs. 1		Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Y) 5-21-195		Co	hplace <i>(Stati</i> <i>untry)</i> n i ngto	
Jsual Residence o 0a. State	f Decedent 10b. County		10c City	, Town or Lo	ncation							10d. Inside	City Limits
				eaton									es No
MD 10e. Street and Nu	Montgo	mery	WII	eaton	10f. Zip	Code			100	Citizen	of What Co	untry?	
					209					USA	TOT WHAT GO	anay.	
2823 Line	Terr pr.	12. Was Deced	ent Ever in U.	S. 13.	Was Deced	lent of Hi	ispanic Orio	nin? (Spe	ecify Yes or No-	14.	Race - Ame	rican Indian,	
 Marital Status □ Never Mari 	ried 2 Marrie	Armed Ford	es? No	1		\sim		, Puerto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.	
3 Widowed	, -	If Yes, Give Year or Dat	,		1 ☐ Yes 2	200	Specify:			Sp	pec <i>ify:</i> b1.	ack	
/0	15. Decedent's	Education		16a. Dece	dent's Usua	al Occupa	ation	of work	ing 16	b. Kind	of Business/	Industry	
Elementary/Seco		grade completed) College (1-4	lor 5+)		kind of wor DO NOT us				1	Soot	ırity	Compan	v
		2		Insta	llati	on 1						par	
17. Father's Name	(First, Middle, L	ast)							e (First, Middle, Ma	iden Su	rname)		
Jessie P	roctor						De1o	is S	Smith				
19a. Informant's N	lame/Relationshi	p (Type. Print)							al Route Number, (-	own, State, Z	Zip Code)	
Celeste	G. Smith	n/wife					St. Wh		on,MD 209				
		3 □Removal from St	ate C	lace of Dispo emetery, cre sapeak	matory or o	ther plac		3-1-			ion - City or sville		
21. Signature of B	uneral Service L	icensee	mo139	Ra	2. Name an	d Addres	ss of Facility	y Crem	.Svc.933	MI Gist	2091 Av.s	0 ilver	Spring
23a. Part1. Enter	the disease, or cart failure. List o	complications that can	used the deatl	n. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory arres	t,		Approxin Interval	Between
Immediate Cause disease or condition	(Final on		nal Me									Onset ar	ia Death
resulting in death)	1	-	r as a conseq										
Sequentially liet or	onditions	b											
Sequentially list co if any, leading to in cause. Enter Under	eriying	Due to (o	r as a conseq	uence of):									
Cause (Disease or that initiated event	rinjury Is	7 c											
resulting in death)	Last	Due to (o	r as a conseq	uence of):									
		d											
IF FEMALE:							****			1			
23b. Was deceder in the past 12			th 2 ☐ Feta	ldeath 3	□Ectopic pr		,			23d	 Date of del Month 	ivery Day	Year
1 ☐ Yes 2	□No	4□Pregna 9□Unknov	nt at time of d /n	eath 5	Other (sp	ecify)						,	
		ns contributing to dea	th hut not roo	ulting in the :	ınderlyina a	ause din	on in Dort I		23e. Did toba	con uso	contribute to	the cause of	of death?
an ii. Utiler sign	meant conditio	s contributing to dea	ar but not res	uning in the t	andenying G	ause yivi	on mr Fäll I.		1 ☐ Yes				Unknown
									1 1 1 1 63			- July 4	-
									24a. Was an autopsy performe		24b. Were au prior to death? 1 □ Yes	completion o	gs available if cause of
25. Was case refe	erred to medical						26. Place	of Deat	th (Check only one)	7140	- Lies	E E E E E	
examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ In	oatient 2	ER/Outpatie	nt 3 DC	Oth	or:		ome 5 Residen	ce 6	Other (Spe	cify) Hos	Pico
27. Manner of Dea		28a. Date of (Month		28b. Time o Injury		28c. Injur Worl			28d. Describe how			27 11 -	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no	ot be 28e. Place of	f injury - At ho g, etc. <i>(Sp</i> ec <i>if</i>	ome, farm, st	treet, factory	, office			28f. Location (Stre City or Town,		Number or Ri	ural Route N	lumber,
	determin	and 28e. Place C	g, etc. (Specif	y) 			ne, date an	nd place,	City or Town,	State)			umber,

To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours after death

Physician /Medical

State

DHMH 17 Rev 1/2001

Registrar

Grenevieve 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

32. Registrar's Signature 6001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mun caster Mill Rd, Rockville, MD

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

4615

29d. Date signed (Month, Pay, Year)

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician p M 2007 31 2:55 07 Violet Louise Sykes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 578-20-7832 Director 84 Washington, DC 1-11-1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it if them 27 is marked other than "natural", or items 23a or 28a-f show ant; if them 27 is marked other than "natural", or items 25a be notified at uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2 No Rockville Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o USA 20853 Funeral 14639 Bauer Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No. Specify: white altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Organization Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Heinemann ဂ Anthony John Grasso 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1514 Lemontree Lane Silver Spring, MD 20904 Patricia S. Bransford/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages:
Department of H
Important; If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory 8-2-2007 933 Gist Ave. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility ma 13 Rapp Funeral & Crem. Svc Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 vulvar cancer 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Pancytopenia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 No ٩ 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) he Hospital or Attending Phy: in 24 hours after death. he Funeral Director; After this pletely filled in by the funeral di this 27. Manner of Death 1 ZiNatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 0 31

DHMH 17 Rev 1/2001

7

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ayag

AUG 0 2 2007

31. Date filed (Month, Day, Year)

1500 Forest Glen

		1 - For State Registrar	State of M	larylar				ealth a Death	and M		Reg. No.	2007	2476
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, L	APP	·)		4b. City	. Town, or	Location o	of Death	2. Date of D Month	Day 3	Year 67 County of Deat	3. Time of Death 3. 45 Q M
Funeral Director	eı	Long Green Cen 5. Social Security Number 6. 476-32-5644	ter		last birthday) Yrs.		Ba1	timo1 If Under 2 Hours	e	8. Date of B (Month, D Jan 25		9. Birti	hplace (State or Foreigr untry) nesota
or death with the Maryland Items 23a or 28a-1 show reconstitues the publiced at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 115 E. Melrose A 11. Marital Status 1 Never Married 2 Married	Venue 12. Was Deceden Armed Forces 1 XYes 2 [B.	ty, Town or Lo	10f. Z		212 spanic Orig	gin? (Spe	ecify Yes or N Rican, etc.)		zen of What Co USA 4. Race - Ame Black, White	ncan Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examiner must be multiled at once.	Be Completed by	3 XWidowed 4 Divorced 15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last Harold Bryan Ta	If Yes, Give Year or Dates Education rade completed) College (1-4or 0)	'53 -	16a. Dece	kind of w DO NOT	ial Occupa	furing most) 18. Mother	r's Name	ng (First, Middl Ouise 1	U.S.	Specify: when dof Business/ S. Army Surname)	
and 2 should ealth and Me n 27 ie mark	٩	19a. Informant's Name/Relationship Myrna Rebling/si	(Type, Print)		1361	9 Cr	ossmo	and Numbe	r or Rura	l Route Num	ber, City or	Town, State, 2	
ermit. Pages 1 lepertment of H mportant: if iter ny injury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Special Societies Formand Societies	ify)	، اس	Place of Dispondemetery, cremetery, cremetery	natory or	other place			655 W		cation - City or	
Physician /Medical Examiner physician and physician and the prinal-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a: Due to (or a: Due to (or a: Due to (or a: Due to (or a:	s a consection of the consecti	quence of):		ore, de of dying		21201 cardiac o		-	dvone	Approximate Interval Between Onset and Death
 requires that the death certifics been signed by the attending pt should be detached for use as the 	Physician/Med	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	aldeath 3□	Ectopi c (.,		2	3d. Date of deli Month	very Day Year
aw requires these sections is been signed 2 should be d	Completed by Pr	Part II. Other significant conditions Ataxia Degeneratie	contributing to death	but not res		nderlying	cause give	n in Part I.		24a. Wa	Yes 2	No 3 ☐ Pro	the cause of death? obably 4 Unknown topsy findings available completion of cause of
g	Certification: To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating inve	28a. Date of Inj (Month, Date)	ury ay Year) njury - At h	28b. Time of Injury	М	28c. Injury Work 1 🔲 \	r: 4 Mur	rsing Hon	1 ☐ Yes (Check only ne 5 ☐ Res 28d. Describe	2 No one) sidence 6 how injury	1 Yes	2 □ No cify) vral Route Number,
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Medical Cer	29a. Certifier (Check only one) 1 Certifying P 2 Medical Example and title of certifier	hysician: To the besiminer: On the basis and manner s	t of my kno	owledge, death	vestigatio	o, in my op c. License	inion, deat	h occurre	and due to the	e cause(s) a	and manner as place, and due signed (Monti	to the cause(s)
Sta Registra		30. Name and address of person who	160 32. Re gist	00 U	J. MT.	Print)				IMORE	MD,	21217	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** d mard 1:21 am 27 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Age (In yrs. last birthday) trince. -ommunite trince Georges neverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 □ F 578 38 4016 Yrs. Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at Georges Yes 2 No Director Krince tort)ashington 10e. Street and Numb 10g. Citizen of What Country? takas or iteme 23a)nited Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 7 Yes 2 □ No 1 W Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or item any njury or other traumatic event, the Madical Exemples Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government abover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Malachi late Matthe late 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5449 Havas 11. Stanton tost Washington MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other pl Method of Disposition 1 Burial 2 ☐ Cremation Date 20c. Location - City or Town, State 3 Removal from State 08 200 Ol! 4 ☐ Donation S ☐ Other (Specify) f Fun ral Service Licens 21. Signatura Runes Funeral Home 22. Name and Address of Facility" John Washington DC 20017 NE at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death
30 UUVS g sease, d allure. Li shock Immediate Cause disease or condition resulting in death) **Physician** /Medical Examiner pertension LLLY. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Examiner Due (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached eart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tyes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 🗌 Inpatient ER/Outpatient 3 DOA this 27. Maprier of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 2 Accident 1 Yes 2 No the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide o the Hospitai Medical 29a. Certifier Ce) tifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examiner and manner stated. mation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature an 9c. License numbe ne of ce 29d. Date sighed (Month, Day, Year) completed cause of death (Item 23a) (Type Print) handarer 32. Alegistrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mo

			1 - For State Registrar	State of N	aryland	-	artment of F		and Mo		giene Reg. No.	17	24762
ı	Physici		1. Decedent's Name (First, Middle							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution Grenesia Pe		n)		4b. City, Town, or			. †	4c. County		1
	Funeral Director		5. Social Security Number 212–58–3930 Usual Residence of Decedent	6. Sex 7. A 1 M 2 □ F	lge (In) a . Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 10-21-	h v, Year)	9. Birth	nplace (State or Foreign untry)
	Marylend e-f show	ctor	10a. State 10b. County	NA	10c. City,	Town or Lo	cation Ltimore				-		10d. Inside City Limits ↑X Yes 2 □ No
	3a or 28	i Dire	10e. Street and Number 1610 Northgat	e Rd.		-	10f. Zip Code	218			10g. Citizen of	What Col	untry?
036	hours after deeth with the Marylend turel', or Items 23a or 28e-f show al Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Nidowed 4 Divorced	12. Was Deceder Armed Forces	i?] No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Ori an, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		ce - Amer ck, White	ncan Indian, o, etc.
21215-0036	within 72 ene. than "nai	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	's Education t grade completed) College (1-4o	r 5+)	(Give life.	dent's Usual Occup kind of work done of DO NOT use retired	du <i>ring</i> mosi d)	of workin	g	16b. Kind of B		·
and 2	be filed tal Hyg od othe event,	o Be C	12th grade 17. Father's Name (First, Middle, Connie	Last)	Toriar		ck Drive			(First, Middle,	Maiden Suman	ne)	mber Co. Hughes
Maryland	12 sh h and 7 is rr treur	-	19a. Informant's Name/Relations		fe	19b. Maili	ng Address (Street				r, City or Town,	State, Z	ip Code)
altimore,	Heal Heal tem 2		Cleopatra Tor 20a. Method of Disposition 1. Burial 2 Cremation 4. Donation 5 Other (S)	3 □Removal from Stat	20b. Pla	ce of Dispo netery, crei	Northyat psition (Name of matory or other place mel Cem.	(e)		ate	20c. Location Dundal		Fown, State
Balti	permit. Peges Depertment of Important: If it any injury or once.		21. Signature of Funeral Service	icensee C	or	22	Name and Address		LIC	rch F.I	H. East		21202
	Priysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caus only one cause on each	ed the death. line.		ter the mode of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
8/60,	tte be executed hysicien and burial-transit and burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	b. An Due to (or a	s a conseque	ence of):							heeks 3 years
P.O. Box 6	that the death certifica led by the ettending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)					te of deliventh	very Day Year
	sign sign	by	Part II. Other significant condition	ns contributing to death	but not result	ting in the u	nderlying cause give	en in Part I.			bacco use conf es 2 No	tribute to	the cause of death?
Division of Vital Records,	The ate h page	Completed	Dm hangertierde-	· //						24a. Was a autop perfor	med?	prior to c death?	topsy findings available ompletion of cause of
OI VIIA	hysician: this certific al director,	To Be	25. W case referr to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death		tient 2 El			er: 4 2 Nu	rsing Hom		ence 6 Oth		ify)
ISIOU	tending leath. tor: After the funer	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r	ation ot be	ay Year)	8b. Time of Injury	Worl	yat k? Yes 2 □ t	No		ow injury occur		ral Route Number,
Ś	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by		29a. Certifier 1 Certifyin	building,	etc. (Specify)	edge, deatl	h occurred at the tim	ne, date and	d place, a	City or Tow	ause(s) and ma	anner as	stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	one) 29b. Signature and title of certifier	Examiner: On the basis and manner:	stated.	on amozor in	29c. License		n occurre		29d. Date signe		
	- 3 + 8		Wend X 6	y mo			D	31295	-		7/24	2/27	_
1	4		30. Name and addr of person winds Klots	who completed cause of	death (Item 2	23a) (Type,	Print) St Su	te yo	202	7 cmsor	m	٨	21204
	Sta Registr		31. Date filed Month, Day, Year)	2 2007 ^{32. Hedis}	trars Signatu	re s	Greater						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 9:35 A M. Jackey H. Utterback 30 ZDD7 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Oct. 5, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1927 1 XM 2 ☐ F 79 Director 577**-**42-9347 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel 1 Yes 2 No Director Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1346 Chapelview Drive 21113 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. once. Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 🛣 No þ Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 1946- 73 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) U.S. Army Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Norman Utterback H. Edith Hurst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hannelore Utterback / Wife 1346 Chapelview Dr., Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug.. 21 2 ☐ Cremation 3 ☐ Removal from State onation 5 Other (Specify) Arlington Nat. Cem. Arlington, Virginia 2007 21. Signal are of Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 SE 23a. Part1. Si er the disease, or complica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (of as a consequence of) Examiner chenne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform 1∐ Yes director 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner' Hospital: 1 Inpatient
28a. Date of Injury 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2 After this funeral 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No ector: by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ä 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar

29b. Signature and title of certifier

30. Name and add

ME

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21215-003

Baltimore, Maryland

Division or Vital Records, P.O. Box 68760

son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month **Physician** JULY EDWARD A. WEDDLE 30, 2007 9:05 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 252 CARROLL RD. PASADENA ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | 8. Date of Birth | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□F MAY 30, 220-20-5916 78 MARYLAND Director 1929 Usual Residence of Decedent flied within 72 hours after death with the Maryland Hygiene.

The "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2 X No Director MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 252 CARROLL RD. 21122 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1948 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 MECHANIC TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental HENRY A. WEDDLE GLADYS VERNON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 Is MARGARET ELAINE WEDDLE WIFE PASADENA, MD 252 CARROLL RD. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. Date, 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 2007 5 ☐ Other (Specify) 4 ☐ Donation Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P. 421 CRAIN HWY. SE; GLEN BURNIE, 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory FAilure **Physician** /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 🗷 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 X No P 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P Certification: (Month, Day Year) Injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu 1 ∏Yes 2 ∏No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 AUGUST 1, 2007 O_{\prime} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Ct. Greenbelt, MD 20770 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 0 2 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTEND of THE WISH POEFFER FOR THE SHOP AND MENTAL Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19, 2007 **Physician** Month 6:28 P M orge July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1X M 2□ F Director Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wir Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a to any injury or other traumatic event, the Medical Examiner must ba gonee. Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sabl Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) (Program) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manager Sanice 20b. Place of Disposition (Name of cemeters remainly or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 12001 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility 105 Ph. Hortz a Funera Ba 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspication **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe deatn? 1 ☐ Yes 2 No 1☐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2

2 T

State Registrar

DHMH 17 Rev 1/2001

D005134

N. Charles St. Baltimore MD

maer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sociano

6701

3 Registrar's Signature

Cyntwa

AUG 0 2

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 7 12:30 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 10 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2 1 Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmas mount of the contract o 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Ş 3 ☐ Widowed 4 ☑ Divorced al Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 □Removal from State 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cicenses 22. Name and Address of Facility

Joseph, L, Rus W. North Ave. Funeral Home ve. Balto. Md. 23a. Part / Enter the diviase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shorts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician e) Mistry disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nermina Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed emers attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months2 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.00 No certificate 1∐ Yes the Hospital or Attending Physician; To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 Inpatient မှ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 4:00 AM M July 23, /Medical Marion E. Webb 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia 6610 Windsor Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 24, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F Yrs. Director 231-26-4965 80 1927 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or ltams 23a or 28a-f ehow the Medical Examiner such the notified at 1 ☐ Yes 2√ No Directo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6610 Windsor Court 21044 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 O <u>retail clerk</u> clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F permit. Pages 1 and 2 should be Department of Heatin and Mental Important: if Itam 27 is marked 1 any injury or other traumatic eventaging. is marked George Evans Nannie Ethridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Kilgore/son 6610 Windsor Court Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Euneral Service Kona I o Licensee S. Ware State Anatomy Board 655 W. Baltimore Street Raltimore, MD 21201 Enter the dis - se, rc mor heart failure. List only remplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Tastatic **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2No 3 Probably 4 Unknown 1 🗌 Yes should should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home Statesidence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident М Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral 12 Certifying Physician: To the basis of my knowledge, death corumed at the time, date and due to the edess(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Itemy 23a) (Type, Print) ittle N 065 Lee, 31. Date filed (Month, Day, Year) 32 Pegistrar's Signature State AUG 0 2 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and N Certificate of Death		erie 0 0 7	24768
	Discontinuo	1. Decedent's Name (First, Middle, Last)	2. Date of Deeth	1	3. Time of Death
	Physician /Medical		July 22	Dey Year	12:30 PM
	Examiner	4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Li	ocation of Death	4c. County of Death	12.50 FM
		7508 Clinton Vista Lane Clinton		Prince Geo	rge's
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		lece (State or Foreign
	Director	231-92-4009 48 Yrs.	April 14	,1959 Gooch	land, VA
	pu M	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	Manyl f sh			'	1 ☐ Yes 2 ☐ No
	the route	10e. Street end Number 10f. Zip Code	10	g. Citizen of What Coun	Λ
	3ª o	7508 Clinton Vista Lane 20735		ited States	•
	ms 2	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispenic Origin? (Sp		14. Race - Americ	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mentel hygiene. Important: If Item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto II Yes, Sive Year or Dates:	Rican, etc.)	Black, White, Specify: Black	etc.
5	72 h	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grede completed) (Give kind of work done during most of work	ing 10	6b. Kind of Business/Inc	lustry
121	rithin ne. han	(Specify only highest grede completed) Elementary/Secondary (0·12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	t for		
72	Her ti	Twelth ISAS	He	oward Unive	rsity
and	Me dot	17. Father's Neme (First, Middle, Last) James Waddy 18. Mother's Name Pauline	e (First, Middle, Ma	aiden Sumame)	
Ž	d Merchantic				
e, Ma	end 2 s leelth en m 27 is i	Larry Baucum/Husband 7508 Clinton Vista Lane			Code)
Baltimore,	Pages 1 ment of H lant: If ite	20a. Method of Disposition 11 Buria Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) County Line Baptist Church Cemetery	7/28/07 0	oc. Location - City or To Goochland,	Virginia
Bal	pemit Depart Import any in	21. Signa, le of Filler I Servi : ligent ee 22. Name and Address of Facility Robe 1661 Good Hope Rd St	ert G. Ma E, Washin	ason Funera ngton DC 200	1 Home Inc
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac cannot shock, or heart failure. List only one cause on each line.	or respiratory arres	st,	Approximate Interval Between
	Physician				Onset and Death
7	/Medical Examiner	Immediate Cause (Final disease or condition Metastatic Pancreatic Cancer resulting in death)			
T	HEED E	Due to (or as a consequence of):			
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ć	tificate be exacuted g physician end es the buriel-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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	death certificete be executed ettending physician end of or use es the buriel-trensitician/Medical Examin	Total II God II Cook		1	
Вох	eath cert ettendin I for use clan/N	d			
	e dea	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	acco use contribute to	the cause of death?
P.0	d by I	Diabetes Mellitus, Type II	1 ☐ Yee	2 No 3 Prob	ably 4 🗆 Unknown
Ś	signe signe d be o				
Records,	The law requires that the death certive has been signed by the ettending page 2 should be deteched for use e Completed by Physician/M		24a. Was an a performe	od? avai	re autopsy findings lable prior to upletion of cause eath?
	hyalclan: The law his certificate hes t il director, page 2 s To Be Compl		1 ☐ Yes	∠ X No 1 □	Yes 2⊠ No
of Vital	ertifica ector, Be (25. Was case referred to medical examiner? 26. Place of Death	(Check only one)		
<u>></u>	Physician: this certific ral director, TO Be	Hospital:	ne 52K Residenc	ce 6 □Other (Specify)	
n o	tal or Attending Prise effer death. al Director: Affer the direct or by the funera ded in by the funera Certification:	27. Manner of Death 1 Natural 5 Pending 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 22c. Injury at Work?	28d. Describe how		
sic	Attending is a death. ector: After by the funer tiffication	2 Accident investigation 3 Suicide 6 Could not be			
Division	or A efter Directif In by	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospital or Attending Physwithin 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place a	nd due to the same	so(e) and manner as	lad
	he Hospit in 24 hour ha Funer pletely fill edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of examination and/or investigation, in my opinion, death occurred at the construction of examination and/or investigation, in my opinion, death occurred at the construction of examination and/or investigation, in my opinion, death occurred at the construction of examination and/or investigation, in my opinion, death occurred at the construction of examination and occurred at the construction of examination and occurred at the construction of examination and occurred at the construction of examination and occurred at the construction of examination and occurred at the construction of examination and occurred at the construction of examination and occurred at the construction of examination and occurred at the construction of examination and occurred at the construction of examination and occurred at the construction occurred at the construction occurred at the construction occurred at the construction occurred at the construction occurred at the construction occurred at the construction occurred at the construction occurred at the construction occurred at the construction occurred at the construction occur	d at the time, date	and place, and due to t	he cause(s)
	within To the comp	29b. Signature and title of certifier 29c. License number		. Date signed (Month, D	ay, Year)
		the Delts Stummen D28079	Ju	1y 24,2007	
1	17	Neme end address of person who completed cause of death (Item 23e) (Type, Print)			
Ú)	Francine A. Higgs-Shipman, 9200 Basil Court, Largo, MD	20774		
	State Registrar	31. Date filed (Month, Day, Year) AUG 0 2 2007 32. Egistrer's Signature			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Young A. Sidney /Medical Juli 20 0-12:50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner MΔ Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 € M 2 □ F 215-70-7212 Director 41 12-18-1965 Md.Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Baltimore 1 XYes 2 No Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 449 E. 23rd Street Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) 10th grade Bechtel Co. Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Newton Edith ၉ Sidney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1815 Woodbourne Ave., Baltimore, Md. 21239 Mother Edith Sanderlin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 8-3-07 <u>Lansdowne</u>. Md. Zion Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March F.H. East M 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Devere /Medical Due to (or as a consequence of): Examiner Strepto Cocous Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Shocked liver Due to (or as a consequence of) the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 npatient 2♥ No ဥ 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day 1 Natural 5 Pending investigation death. 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Records, P.O. Box 68760. Division or Vital To the Hospital or Attending Physician: Director: within 24 hours a To the Funeral I

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 0

Elie

29b. Signature and title of certifier

29a. Certifier



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201 E. umiver 32. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.-Time of Death Day **Physician** 7:55 PM Young Margaret Mary 2007 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner FOR enler If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months . Days Min. 1 □ M 2 🗓 F Hours 216-34-3280 68 **Director** 1938 Maryland Oct. 3, Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 9903 Magledt Road 21234 U.S. A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items dical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 💢 No Specify. þ Specify: 3 X Widowed 4 ☐ Divorced White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elizabeth Conlon Joseph Leonard Bankert ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Rausch (Dghtr) 703 Weatherby Ct., Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/28/2007 Gardens of Faith Baltimore, Maryland 22. Name and Address of FacilitySchimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryalnd 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (our as a consequence burial-tra resulting in death) Last Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 0 10 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No Hospital: 1 ☐ Yeş 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) Mann r of Death Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29b. Signature and title

29c. License number

Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

8 State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

30. Name and a

(Check only one)

Registrar's Signature

ess of person who completed cause of death (Item 29a) (Type, Print)

Spark

filed within 72 hours after death v Hygiene.

Maryland 21215-0036

Baltimore,

law requires that the death certificate be executed

The certificate

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Day Year 4:50 M **GEORGE** 2007 ZABETAKIS 21 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ton Medical Center Jen Burnie Paltimorellashin Hone Hrunde If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 219-32-9582 1935 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 108 LINWOOD AVE. Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: KOREA 1 Never Married 2 Married 1 ☐ Yes 2 🐼 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JOHN ZABETAKIS JULIA POPECK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOLA ZABETAKIS / WIFE 108 LINWOOD AVE. GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State AUGUST 4 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 GLEN HAVEN MEM. PARK GLEN BURNIE, MARYLAND Juneral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 21. Signature 421 CRAIN HWY. SE; GLEN BURNIE, MD 21061 ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ocard hars /Medical Due to (or as a consequence of): Examiner week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Physician:

burial-trar physician the attending ph page 2 s director, funeral After Hospital or Attending after death filled in by within 24 hours a To the Funeral C completely

"natural", or items 23a or 28a-f show

Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, th

George

LOD OPEKIS

Maryland 21215-0036

Baltimore,

Pages 1

traumatic event, the Medical Examiner must be notified at

Medical

State

1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Dav. Year)

THE WID

4387

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical

herles 301 2

Registrar

29b. Signature and title of certifie

29a. Certifier

			Please	State of Manuford /			•	_						
			1 - For State Registrar	State of Maryland / I	•	ate of Death	•	2 11 17	21,772					
		104			Certifica	ale of Dealif		Reg. No.	2 Time of Death					
	Physici	an	Decedent's Name (First, Middle, La	(St)	llen		2. Date of De Month	Dav Year	3. Time of Death					
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7	Examir	ner	4a. Facility Name (If not institution, given		4b. C	ty, Town, or Location of Deat	h	4c. County of Deat	h					
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20,	Funeral		,	Sex 7. Age (In yrs. last bi		der 1 Year If Under 24 Hrs ns Days Hours Min.	(Month, Da	th (y, Year) 9. Birth (Co	hplace (State or Foreign buntry)					
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pue	A H		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits					
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a c	28a	Director	Maryland Prince 10e. Street and Number	George's	10f.	Temple Hi	LIS	10g. Citizen of What Co	untry?					
ži,	Sa or		2503 Easton	C+		20748	1	United	States					
5-0036	then "natural", or itema 23a or 28a-1 show then "natural", or itema 23a or 28a-1 show the Medical Examinar must be notified at	Funeral	11. Maritaf Status	12. Was Decedent Ever in U.S.	13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer			rican Indian,					
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aryla should be	Mental arked o	To	Eugene Al	len			Eliz	zabeth Cross	S					
Maryland 21215-0036	and M		19a. Informant's Name/Relationship	Type, Print) 19t	. Mailing Addr	ess (Street and Number or R	urai Route Numb	er, City or Town, State, 2	Zip Code)					
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Baltimore,	f of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [cameta	of Disposition (in the control of th	Name of or other place)	Date	20c. Location - City or	Town, State					
E	2 4 6 5		4 □ Donation 5 □ Other (Speci		1n Memo	rial Cem. 7/2	3/2007	Suitland	MD					
at	Departm importa any inju		21. Signature of Funeral Service Lice	nsee 1	22. Name	and Address of Facility	Stewart	Funeral Ho	ome					
	10 F # 9		John 1.	allword, I	4	001 Benning R	d., NE	Wash., DC 2	20019 Approximate					
=		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faifure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of): Cause (She are the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Security of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.												
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Box	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death	3 □Ectopia 5 □ Other	pregnancy		23d. Date of del Month	Day Year					
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Di Hospitai or	within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	O	29a. Certifier 1X Certifying P	hysicien: To the best of my knowledg	e, death occur	red at the time, date and place	e, and due to the	cause(s) and manner as	s stated.					
Hos	24 h Fur etely	edical		miner: On the basis of examination ar and manner stated.										
o the	within 2 To the complet	Me	29b. Signature and title of certifier		11	29c. License number		29d. Date signed (Mont	Day, Year)					
/			A H	+		35826		7/13/	07					
1	8)		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)	33826								
(/ DC			piro, M.D. 7600		l Ave Takom	a Park.	MD 20913						
1 to 1	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	JULI 01.	Jakom	LULKS	LUJIJ						
30	Regist		JUL 1 9 2007 A											

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 16, 2007 Year **Physician** July 6:16a M Susie Jane Bolin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital Date of Birth (Month, Day, Year)
11/18/1909 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 ☐ M 2 🕟 F 073-07-3900 New York 97 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" ~- " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Prince George's Largo 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20774 10505 Broadleaf Drive USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co. 4 Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Stearns George Scamp ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10505 Broadleaf Drive Largo, Md. 20774 Donald E.Bolin/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 TrBurial 2 ☐ Cremation 3X Removal from State 7/19/2007 Watsontown, PA. 4 ☐ Donation 5 ☐ Other (Specify Watsontown Cem. 21. Signature of Funeral Service Lic PHILIP D. RINALDI FUNERAL SERVICE, P.A. 1 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown ts been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? Yes 2X No certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 1 🕅 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury

Division or Vital Records, P.O. Box 68760,

funeral director, After To the Hospins...
within 24 hours after death...
To the Funeral Director: A!

1 XNatural 2 Accident

(Check only

29a. Certifier

investigation 6 Could not be determined 3 Suicide 4 THomicide

5 Pending

(del Jayant,

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number DO52586 29d. Date signed (Month, Day, Year) July 16,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18

2007

Jayanti Patel MD

JUL

1500 Forest Glen Road Silver Spring, Md 20910

State Registrar

Medical

32. egistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 9 2007

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State Registrar 31. Date filed (Month,

Day,

32. Registrar's Signat

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Registrar

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4	/Medic Examin		4a. Facility Name (If not institution, giv		ber)		4b. City, Town, or	Location of Dea		4c. County of Death	
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	Funeral Director		Social Security Number 6.5		7. Age (In yrs.				8. Date of Birt (Month, Da		place (State or Foreign
Koge	Q ·		577-56-9637 Usual Residence of Decedent 10a, State 10b. County			y, Town or Lo	cation		02-16		sh., DC
	i within 72 hours after death with the Maryland liene. I than "naturel", or Items 23a or 28s-f show I'rs Medical Exanirar must be notified at	tor	DC				ington,	D. C.			1 Yes 2 No
	r 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Cou	ntry?
	h wit		2430 Monroe St	reet,	N.E.		200	18		USA	
	deal ms	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Specify Yes or No	- 14. Race - Ameri Black, White,	
36	or lo	y Fu	Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes If Yes, Give Year or Da	2 1 2 No		1 □ Yes 2 No	Specify:	MIL!		lack
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Maryland	and and and		19a. Informant's Name/Relationship (ahter)					er, City or Town, State, Zij	Code)
Baltimore,	Pages 1 and 2 nent of Health int; if Item 27 iny or other tre		20a. Method of Disposition 1 ☐ Burial 2☐€remation 3 ☐	Removal from S	20b. P	lace of Dispo	SS35, V esition (Name of matory or other place	9)			
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Sor	w require been si should I	lete	RENAL FA						24a. Was	an 24h Were aut	opsy findings available
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_	Hospita 14 hours Funaral tely filled	Medical C			sis of examina					cause(s) and manner as date and place, and due	
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1	U		30. Name and address of person who DARCLE M	MAN	ME	1 ZJa) (Type,	300 Picc	card Di	e. Suitez	or Rockvill	e Md.20850
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 9 2007	Janes Janes	egistrar's Signa	Sperio	U				

DHMH 17 Rev 1/2001

	i I		1 - For State Registrar	State of Ma	-	epartment of I Certificate of			iene eg. No.	
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г	Physici		Sophia J.	Brow	n			July 15	Day Year 2007	8:58 P M
Agree	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town,	or Location of Deat		4c. County of Death	
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	Funeral			3. Sex 7. Age 1 ☐ M 2 🗓 F	(In yrs. last birtl	nday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) Cou	nplace (State or Foreign untry)
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	th the or 28)ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath w	Funeral Director	1225 Trinidad S			20002			United Sta	
	er de	aun	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
36	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	1 □ Yes 2 X No	Specify:		Specify: B1:	ack
21215-0036	2 hou atura cal E	ted	15. Decedent's	Education		Decedent's Usual Occu			16b. Kind of Business/I	ndustry
215	thin 7	ple	(Specify only highest Elementary/Secondary (0-12)	Gollege (1-4or 5+		Give kind of work done life. DO NOT use retire	ed) ed)	rking		
2	ed wil	Completed		2	Civi	llian Schoo			Department	of ARMY
nd	be fill tal H sd oth	Be	17. Father's Name (First, Middle, La	ast)				me (First, Middle, I	Maiden Surname)	
<u>\S</u>	ould Mer narke	P	David O. Brown 19a. Informant's Name/Relationshi	n (Time Drint)	106	Mailing Address (Street		a Peters	; City or Town, State, Z	in Cada)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Jan F. Brown, S		I T	225 Trinida			hington, D	
re,	os 1 au of Hea item		20a. Method of Disposition		20b. Place of cemeters	Disposition (Name of crematory or other pla	ace)	Date	20c. Location - City or	Fown, State
<u>m</u>	Page nent c int: If		¶∏ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1	incoln Ceme	tery 7/		Brentwood,	
Baltimore,	ermit. epartn ports ny Inju		21. Signature of Funeral Septice Li	censee					n Funeral 1	
Ш	9 Q F % 9		Sechel flow-	<i>IF</i>		J.	lensburg		rentwood, l	
a			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused the nly one cause on each line	the death. Do n e.	ot enter the mode of dy	ring, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Chronic	Obstruct	ive Pulmor	ary Dise	ase		
	Examiner			Due to (or as a	consequence o	f):				
le:		er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	ı consequence o	f):			8	
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	c.						
Ö,	e exerian ar	Ex	resulting in death) Last	Due to (or as a	consequence o	f):				
38760,	cate be executed physician and the burial-transit	dical	'	d						
w.		/Me	IF FEMALE:	23c. If yes, outcome p	of pregnancy					
Box	death certiff e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2	2 Fetal death	3 ☐ Ectopic pregnants ☐ Other (specify)	су		23d. Date of deli Month	Day Year
o.	the che	nysic	1 ☐ Yes 2 🖰 No 9 ☐ Unknown	9□Unknown	anio oi doda	o 🗆 o mon (aposary)				
Δ.	The law requires that the death certifute has been signed by the attending vage 2 should be detached for use as	by Pł	Part II. Other significant condition	s contributing to death bu	t not resulting in	the underlying cause g	iven in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
rds	quires en sig uld be	q pe						1 X Y	es 2 No 3 Pro	obably 4 □Unknown
900	2 88 2	plet						24a. Was a		topsy findings available completion of cause of
Ě		Completed						perform	med? death?	2 □ No
/ita	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	11				ath (Check only on		
Division or Vital Records,	Physician: this certific ral director,	ပ္	1 Yes 2X No 27. Manner of Death	Hospital: 1 Xinpatier 28a. Date of Injury		Datient 3 DOA			ence 6 Other (Spec	city)
uc	ding F	ion:	1 X Natural 5 ☐ Pending	(Month, Day		jury Wo	ork? □Yes 2∐No	200. Describe no	ow injury occurred	
İSİ	or Attending after death. Director: Aftel	ficat	3 Suicide 6 Could no	ot be 28e. Place of injur	ry - At home, fan	m, street, factory, office		28f. Location (S	treet and Number or Ru	ral Route Number,
<u>S</u>	al or / after I Dire d in b	Certification:	4 ☐ Homicide determin	building, etc.	. (Specify)			City or Town	n, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			Physician: To the best o						
	the H hin 24 the F	ledical	one)	and manner stat						
	To 1	Σ	29b. Signature and title of certifier	Pote/Tayant.	el .		nse number	2	9d. Date signed (Monti	
)52588		7/18/20	U /
L	(10)		30. Name and address of person was Jayanti Patel:			Type, Print) st Glen Roa	ad, Silve	r Spring	20934	
	Sh	te	31. Date filed (Month, Day, Year)				,	1 - 0		-
	Registr	W.	JUL 1 9 2007	Seen D.	r's Signature					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylar		artmen rtificat			and M		eg. No.	007	247	79
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Deat Month	th Day	Year	3. Time of E	Death
	/Medic		Sylvena C.								July _	15	2007	1534	
	Examin	er	4a. Facility Name (If not institution,		,		4b. City,		Location o				inty of Death		
			Ft. Washing			last birthday)	If Under		If Under		gt.on 8. Date of Birth			George	
1	Funeral Director		578-46-8583	1□M 2□XF	. Ago ().13. . 7 !		Months		Hours	Min.	Month, Day,	Year)		place (State or ntry) nsylvan	
			Usual Residence of Decedent								Dep. 12.	. 1931			
	nrylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City	
	Ba-1 s	Director		George's	3				shin	gton				1X Yes	Z [] NO
	with the		10e. Street and Number				10f. Zip	Code			1		of What Coul		
	eath i	Funerai	12021 Living	ston Road		IS 12	Was Docor	tent of Hi	2074		city Ves or No-		rited S		
	iter d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Ford	es?		If Yes, spec	ify Cubai	n, Mexican	, Puerto F	cify Yes or No- Rican, etc.)		Black, White,		
93	hours after death with the Maryland tural; or Items 23a or 28a-f show al Exercitive Intel be inclifted at	b	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dat			1 ☐ Yes	2∏ No	Specify:			Spe	ecity:	rican	
5-0	n 72 hours after death with the Marylar "natural", or Items 23a or 28a-1 show edical Exercities mast be molified at	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usua kind of wo	il Occupa	ition	of working	na		f Business/In	dustry	cc
2		mpie	Elementary/Secondary (0-12)	College (1-4	tor 5+)	life.	DO NOT us	e retired,)		3		ce nou ernmen	se Sta	II
2	be filed withintal Hygiene. Ind other therevent, the Merene.		10th 17. Father's Name (First, Middle, La	ent!		1	H.c	usek	eepir		(First, Middle, I				
and	ould be f Mental H warked of watic ever	Be	Arville Carte						15. MOUTO	i s ivaille	Lula M				
Ž	2 should and Men is marke sumatic	^L	19a. Informant's Name/Relationship			19b. Mailii	na Address	(Street a	nd Numbe	r or Rura	Route Number			Code)	
Maryland 21215-0036	T In		Geraldine R. Mit		ghter						xon Hil			·	
ē,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other is ance.		20a. Method of Disposition		20b. I	Place of Dispo cemetery, crei	sition (Nan	ne of ther place	9)	D	ate	20c. Location	on - City or To	own, State	
E	Page nent c int: If		1 ☐Burial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Spe		ale					7/24	/2007	Su	itland	• MD	
Baltimore,	rmit. spartn poorte y inju	21. Signatur of Funeral Service Licensee 1. Incoln Memorial Cem. 22. Name and Address of Facility Stewart							Funeral Home						
<u>—</u>	205 2	1	John !	Dlewa	JUL, JU						., NE W		DC 20		
			23a. Part1. Enfler the disease, or co shock, of heart failure. List or	omplications that car nly one cause on each	used the deat ch line.				•					Approximate Interval Betwo Onset and De	
	Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a. Atteroschools (Cardwascular disease)													
ı	Examiner	Due to (or as a consequence of):													
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (o	r as a consec	quence of):	-								
	outed Id ransit	Examiner	Cause (Disease or injury that initiated events	c.											
ó,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (o	ras a consec	juence of):									
8760,	icate b physic s the b	dical	8	d					-						
9 X	death certifica e attending ph od for use as th	/Med	IF FEMALE:	23c. If yes, outco	ome of pregn	ancv						224	Date of delia		
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bir	h 2 ☐ Feta nt at time of c	al death 3	Ectopic pr					230.	Date of delive Month	Day Ye	ar
P.O.	the y th	Physician/M	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknov	m										
	law requires that the de as been signed by the a 2 should be detached t	by P	Part II. Other significant condition	s contributing to dea	th but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did tot	oacco use c	ontribute to t	ne cause of de	ath?
ğ	w require been sign		Maberes	4-							1 □ Ye	s 2 🗆 No	o 3 ☐ Prot	pably 4 Un	iknown
Records,	e law n has be je 2 sh	Completed	Hyperter	son							24a. Was a autops	V	prior to co	psy findings av	vailable use of
E B	Th afe pag	Con	, ,								perform 1 ☐ Yes 2		death?	2/No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		,		Othe		of Death	(Check only on	e)			
to	Phys this rai dia	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 1111		ER/Outpatier 28b. Time o		M	4 🗀 1901		ne 5 🗆 Reside			y)	
o	Attending I r death. octor: After	tion	1. Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of (Month,	Day Year)	Injury	м	8c. Injury Work 1 □ Y	? ′es 2 □ l			,,			
Division	of or Attendate after death	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place o	f Injury - At h	ome, farm, str	eet, factory	, office		2	8f. Location (St		ımber or Rura	I Route Numb	er,
ā	tal or s afte al Dir	Certification:	4 - Homelde	building	, etc. (<i>Speci</i> i						City or Towr	i, State)			
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical		Physician: To the b											
	the hin 24 the F	Med	one)	and manne				License					aned (Month,		
	To To	_	29b. Signature and title of dertifier	n				-0	74(1	7	(- p-1)	1	∟ay, 10d1)	
1	2		30. Name and address of person wi	no completed cause	of death /Ites	n 23a) /Time		14	1 -((117		1		
- (8)		Cawhne	J Care	re 1	1701	2	VIV	ig5	Im	Rd	A	Wash	instor	MO
	Sta		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Sign	Prints of 5								1	
	Registr	ar	յսլ 2 0 2007	Denew !	7. P	ALL STREET									

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07.	-เมฉ	5/1	0

aul Benjamin Bo	1	- For State	State of I	Maryla		oartment o <i>ertificate o</i>			Menta	al Hyg		eg. No.	W 4	7,7
Physicia	n/	Registrar 1. Decedent's Name (First, Mi								2	Date of Deat Month July 13, 20	th		3. Time of Death 2129 hrs
ledical Examin		Paul Ben 4a. Facility Name (if not institu					4b. City, T	own, or L	ocation of	Death	July 13, 20	4c. County o	f Death	
		Prince Georges Hos	pital Cent	er			Cheve	erly				Prince G		
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs	s. last birthday)	If Unde	r 1 Year s Days	If Under Hours	24Hrs.		th(MM/DD/YYYY)	Foreign	า
Director		579-84-0995	1 X M	2F		48 Yr					10/08	8/1958	NSA	Tth Carolina
MA CONTRACTOR OF THE CONTRACTO		Usual Residence of Decedent 10a. State 10b. Cour			10c. C	ity, Town or Loca	tion							10d. Inside City Limits
*	_	DC						Was	hingt	ton				1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number					10f. Zip	Code		_	1	0g. Citizen of Wh		
		3415 Car					<u></u>	- : :	2002					States
ath wit items 2 st be r	Funeral	11. Marital Status 1 X Never Married 2	Married 12.	Armed F		If '	as Decede res, specif	nt of Hisp y Cuban,	Mexican,	n? (Spe Puerto R	cify Yes or No tican, etc.)	- 14. Race White	- Americ	can Indian, Black,
fter de		3 Widowed 4	Divorced If Ye	Yes s, Give Ye	2 X No	1_	Yes 2	X No	specify:			Specify:		erican
so = = =	g p	15. Decedent's Education (S) 16a. Decede			on (Give ki			16b. Kind of Bu	siness/li	ndustry
7 , -] jet	Elementary/Secondary (0-	2)	College (1-4 or 5+)									
15-0036 He within 72 hour Hygiene. d other than "natu	Completed	11th 17. Father's Name (First, Mid	ile, Last)			M	<u>ainte</u>	nanc 1	e/Eng 8.Mother's	zine Name (er First, Middle, I	Gov Maiden Surname	ern n	ient
21215 uld be file Mental Hy marked o	Be	Walt	er Bon	ner							Doro	othy Nel	son	30
MD 21215-0036 12 should be filed within 7 th and Meintal Hygiene. 127 is marked other than unatic event, the Medica	မ	19a. Informant's Name/Relati				1					ral Route Nur	mber, City or Tow	n, State	
	-	Eleanor L 20a. Method of Disposition	. Bonn	er/S:	ister 20	b. Place of Dispo	900 T sition (Nar	estw ne of cen	ay Av	7e	Ft. War	20c. Location	20 City or	744 Town, State
Baltimore, M Permit. Pages 1 and 2 Department of Health Important: If item 2		1 X Burial 2 Crema		Removal f	from State	crematory or o	ther place)	İ	- 40		_	_	
드 리 의 플 닝	Ì	4 Donation 5 Other 21. Sign, ture of Tuneral Serv	Specify: ice Licensee			Harmony 22.	M <u>emor</u> Name and	<u>ial</u> Address	Parkl of Facility			Lar Funeral		
Balti permit. Departm Importi injury		John T	to	Nocu	# III		40	01 B	ennir	ne Ro	d. NE	Wash	DC	20019
Physician		23a. Part Enter the disease failure List only one ca			caused the de	ath. Do not enter	the mode	of dying,	such as ca	rdiac or	respiratory ari	rest, shock, or he	art	Approximate Interval Between Onset and
/Medical Examiner		Immedia Cause (Final dise or condition resulting in deat	_	tiple In	juries a consequenc	on of):				_			_	Death
J		Sequentially list conditions,	b	to (or as	a consequenc	.e or).								
	直	If any, leading to immediate		to (or as	a consequenc	ce of):								
recuted and transit	Examine	(Disease or injury that initiate events resulting in death) La		to (or as	a consequenc	ce of):								
O, : be executed sician and burial - transi	dical	UNPENDED		MENDED										
	₩ #	IF FEMALE: 23b. Was decedent pregnant			, outcome of p			2	Estania	prognar	2011	23d. Date of Month		y Day Year
Box 6876C death certificate the attending phys	Physician/M	past 12 months?	4	Live Preg	pirth Inant at time o	f doath	etal death Other (Spe		Ectopic	pregnar	icy	World		Say 100.
BO) e death the att	hys		Unknown g								ODe Did	tobacca uso conti	dhuta ta	the cause of death?
Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Fineral Director: After this certificate has been signed by the attending physipletely filled in by the funeral director, page 2 should be detached for use as the b	P.	Part II. Other significant co	iditions cor	ntributing	to death but n	ot resulting in the	underlyin	g cause g	iven in Pa	π, ι.				bably 4 Unknown
ords, law requires is been signatured be	Completed										24a. Was			topsy findings available
COF e law r e has b	ğ	· ———						_			auto perfe	ormed?	death?	completion of cause of
Vital Recc ysician: The la his certificate ha director, page 2	ပ္မ	25. Was case referred to me	lical					26.Place	of Death (Check o		2 110		
Vita hysicia this ce	i B	examiner? 1 ✓ Yes 2 No	Hosp	oital: 1	Inpatient 2	✓ ER/Outpatie	nt 3 🗌 1	DOA	Other ₄		Home 5	Residence 6	Othe	r:
Division of ¹ pital or Attending Phours after death. reral Director: After tilled in by the funeral		27. Manner of Death Natural 5		28a. Dat	e of Injury th Day Year) 2007	28b. Time o 2013 hrs	Injury	_	ry at Work	lo		how injury occur auto fixed obj		Ilision
Sior Attend death death sctor:	gţi		ending rvestigation	0.00		At home, farm, str	eet factor		res 2	_	28f Location	(Street and Numb	er or Ru	ural Route Number, City
Divi	Certification:		ould not be etermined		Docal S		eet, 140tor	y, 011100 B	onding, or	. F	or Town, Ft. Davis Dri	State) ve @ Massach	usetts /	Avenue, SE Washing
Hospit 24 hou Funer tely fil	2	29a. Certifier 1 Certifyin	g Physician:	To the be	est of my knov	vledge, death occ	urred at th	e time, da	ate and pla	ice, and	due to the cau	use(s) and manne	r as stat	ted.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	one) 2 Medical	ı and	the basis d manner	s of examination	on and/or investig				curred at	the time, date	e and place, and		
- > - 0	ž	29b. Signature and title of ce	rtifief	1	10		29	o.C.I	e number M F			July 14, 20		onth, Day,Year)
		2010	WV	plated ==	use of death /	Item 2221		0.0.				July 14, 20		
TE (1)		30. Name and ad ress of pe Susan Hogan MD.	0.3	d.	iuse of death (ical Exami		nn Stre	et, Balt	imore, N	MD 212	201			
St	ate	31. Date filed (Month, Day, Y	par)			Specific .	_							
Regist		nn 2 0 200	1 5		17.	Manual.								

Gerardo	Gomez	Cruz
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e Legible.		
ne	2007	2478
Reg. No.		

	1- For State Certificate		Reg. No.
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De Month July 24, 3	
Medical Examiner	Gerardo Gomez Cruz 4a. Facility Name (if not institution, give street and number)	July 24, 4b. City, Town, or Location of Death	4c. County of Death
	14605 Bowie Road # 202	Bowie	Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 1 1 2 F 3 8	The state of the s	Sirth(MM/DD/YYYY) 9. Birthplace (State or Foreign E1 Country) Salvador
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Maryland Prince George's	aurel	1 X Yes 2 No 10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.		20707	El Salvador
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she r transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) X Yes 2 No specify: Salvadorat	White, etc.
urs after turral"	or Dates:	edent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
5-0036 et within 72 hour lygiene. tygiene. tother than "natu in Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 3rd	ng most of working life. DO NOT use retired)	State Highway Contractor
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple		18.Mother's Name (First, Middle	e, Maiden Surname)
D 21215-0036 should be filed within 72 and Mernal Hygiene. 7 is marked other than natic event, the Medical To Be Comple	Eulofio Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. M	Petrona Cruz ailing Address (Street and Number or Rural Route N	iumber, City or Town, State, Zip Code)
MD 21 nd 2 should alth and Mey m 27 is magnunatic ev	Tomas Cruz/brother 910	O Scottadam Court #X2 La	urel, Md., 20708
lore, N ges I and in of Health t: If item	1 X Burial 2 Cremation 3 Removal from State remaining Type	sposition (Name of cemetery, or other place) Cemetery 07-30-07	20c. Location - City or Town, State El Salvador
Baltimore, permit. Pages 1 at Department of Het Important: If ite injury or other tr	4 Denotion 5 Other Specific	22. Name and Address of Facility W.H. Baco 3447 14th Street, N.W.	n Funeral Home, Inc.
Physician	23a. Párt i. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.		
/Medical aminer	Immediate Cause (Final disease or condition resulting in death) a. <u>Ischemic heart disease</u> Due to (or as a consequence of):		Death
n 5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ed nsit Examine	cause. Enter Underlying Cause (Disease or injury that initiated expects regulting in death). Last		
760, icate be executed physician and the burial - transit	a		
760, cate be executed physician and he burial - transi	X UNPENDED #MSNDED #25a,FII,27,perME,g871	, 9/4/07 TT	
O.O. Box 68760, that the death certificate be need by the attending physic detached for use as the burthy Physician/Med	123h Mac decodent pregnant in the	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
. Bc the dea y the a	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Di	d tobacco use contribute to the cause of death?
P.O. P.O. Strate es that be deta	Sovere seizure disorder	1	Yes 2 No 3 Probably 4 ✔ Unknown
Livision of Vital Records, P.O. Box 687 To the Hospitol or Attending Physician: The law requires that the death certifivithin 24 hour after ceath. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as to deficient Certification: To Be Commisted by Physician		pe	prior to completion of cause of death?
I. The lifficate r., pag		26.Place of Death (Check only one)	es 2 No 1 Yes 2 No
Vital ysician his cert directo	examiner? Hospital:	atient 3 DOA Other Nursing Home 5	Residence 6 🗸 Other: Scene
Vision of Vital or Attending Physician: After death. Director: After this certif in by the funeral director. To Be in the fifter of the fire of the fifter o		ne of Injury 28c. Injury at Work? 28d. Descri	be how injury occurred
Livision o spitel or extending your after eath. neral Director: After filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)		on (Street and Number or Rural Route Number, City n, State)
Hospi 24 hou Funer tely fill	2	occurred at the time, date and place, and due to the destigation, in my opinion, death occurred at the time, d	cause(s) and manner as stated. ate and place, and due to the cause(s)
To the within To the comple)	29c. License number	29d. Date signed (Month, Day, Year)
	Afbra Brassell MD	O.C.M.E.	July 24, 2007
R(2)	Michigon Brooden; MB Transfer Methods	11 Penn Street, Baltimore, MD 21201	
Stat Registra	e 31. Date filed (Month, Day, Year) 32. Registrar's Signar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2007 Kathleen Lucinda Chouinard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Memorial EASTON TAIDOT if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 31 | 1932 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√F 75 Yrs May Director 130-26-1348 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ms 23a or 28a-f shor must be notified at Director 1 ☐ Yes 2 No Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 12351 Ridgely Road Funeral 21660 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 7 is marked other than "natura!", or Iten traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by White 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) <u>horticulturalist</u> nursery business permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any Injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James McMullen ပ Jemima Thomplinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son Arthur F Chouinard, 12365 Ridgely Road; Ridgely, Maryland 21660 ce of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemet 7/26/2007 Greensboro, MD 21. Signatur / Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Onset and Death Immediate Cause (Final **Physician** N monas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading a immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 ☐ Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No page 2 autopsy performed? Yes 22 No certificate Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner' inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Noves 2□ No Certification: To After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 1 Natural Injury 5 Pending investigation NIA 1 ☐ Yes 2 ☐ No 2 ☐ Accident NIA N/Awithin 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064381 21/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

JUL 2 3 2007

KERNS

₫32. Registrar's Signature

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Seminate Water Name (Included Seminate Control Seminate S		Physicia	an	. Decedent's Name (First, Middle, Last)	L		2. Date of Deat Month	th Day Year			
TOUR PRINCIPLE DECORPTION OF THE PRINCIPLE OF THE PRINCIP			er	a. Facility Name (If not institution, give street and number) Genesis HealthCare – The	Pines	Easton	Peath	4c. County of Death	n ot		
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Physician (Medical Examiner) Physic	e, Mary	lealth and A m 27 is ma her trauma	3	19a. Informant's Name/Relationship (Type, Print) Carol Schwartzkopp Daughter	24 Cc	oventry Road, Re	ehoboth Bed	ach, Delawa	re 19971		
Physician (Medical Examiner) Physic	Mich Himore	ortment of H	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cometery, crer aryland eterans	castern Shore Cametery 7	/25/2007	,			
Physician (Medical Examiner) The part of the part of	Ba	Depe impo		23a Part 1 Enter the disease or complications that caused the d	1	oore Funeral How 2 South Second	Street, Der	nton, Maryl	Approximate		
1 Yes 2 No 3 Probably 4 Morkown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Morkown 24a. Whis an autopsy performed; 1 Yes 2 No 3 Probably 4 Morkown 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Morning of Death No print 1 Yes 2 No	E	/Medical xaminer	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Affanosic	derosis	My dizease			years		
30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)	O. Box 6	the ettending p	ıysiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	etal death 3				,		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	rds, P.	n signed by	by		-	nderlying cause given in Part I.					
30, Name and address of person who compreted cause of death (Item 23a) (Type, Print)	al Reco	cete hes bee		Dementie Chronic obstructive p	almonay	y dispose	performed? death?				
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30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)	of the Hose	within 24 ho	Medica	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, deat nination and/or in	vestigation, in my opinion, death of	occurred at the time, d	ate and place, and due	to the cause(s)		
and the same and an analysis of the same and		- > - 0		30. Name and address of person who completed rause of death (Item 23a) (Type	7725953		7.23.	07		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 21 Year **Physician** Oris 2007 ouise /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner In 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Washing Washington

5. Social Security Number Mosp, ta Birthplase (State or Foreign Country) If Under 1 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 84 MARCH 29. 1923 MARYLAND 219-14-8671 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic everal. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 X No KEEDYSVILLE Director MARYLAND WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21756 5222 HOLLOW TREE LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR SHOE MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDNA FORD JOHN GLENN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5222 HOLLOW TREE LANE, KEEDYSVILLE, MARYLAND 21756 HARRY M. CROWL JR./spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BROWNSVILLE HGTS CEM 07/26/2007 BROWNSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sure of Funeral Service censee 22. Name and Address of Facility
BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland Kelly A. Zimmerman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or deart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hours **Physician** /Medical Due to (or an a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 Onknown Cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed? Yes 2 page 2 certificate Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 Medical Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? (Month, Day Year) To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No r death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the i 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pajman Alexander Danai, 251 Antictam Avenue Hagerstom, MD 21740 Pajman Alco

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** 5:45PM Bert July 14, August. Carver /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F **Director** 525-38-0742 13. 1925 New Mexico Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐Yes 2☐No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 14400 Homecrest Road, #209 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 √Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White ò 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced "natural" tal Hygiene.

J other than "natura event, the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Applied Physics Elementary/Secondary (0-12) College (1-4or 5+) Electrical/Mechanical Laboratory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental tem 27 is marked of Jennie Piccamon Albert Carver ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14400 Homecrest Road, #209, Silver Spring, MD 20906 Julia F. Carver/Wife item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1∰Burial 2 □Cremation 3 □Removal from State Gate of Heaven Cemetery July 19 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signatur of Funeral Service Licen 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, assess on each line. 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Cardiomyopathy /Medical Due to (or as a consequence of) **Examiner** Non-Sustained Ventricular Tachycardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Recurrent Aspiration Pneumonia and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical d. MRSA IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☑ Unknown Chronic Left Lower Extremity Ulcer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1□ Yes 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1√☐ Inpatient 2 ER/Outpatient 3 DOA မှ 1 🗌 Yes 2 No 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2007 20+1 D64189 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Rama Kapoor, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature 18 Registrar

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· · · · · · · · · · · · · · · · · · ·	Physici	an	Decedent's Name (First, Middle, Last)	17:11-1		0.0.000	2. Date of Death	Day Year	3. Time of Death
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-	Examir	er	7205 PINEY WOOD		LA	UREL		PRINCE	GEORGE
	Funeral Director	-	5. Social Security Number 6. Sex 216 96 7927	7. Age (In yrs. ia M 2 F 96	Yrs. If Unde Months		8. Date of Birth (Month, Day, Ye APRIL 14		nplace (State or Foreign untry) S. KOREA
	TO TO		Usual Residence of Decedent 10a. State 10b. County		Town or Location		APRIL 1'	‡ 1 T Z T T	10d. Inside City Limits
	Maryla -f sho	ţō	MD PRINCE		UREL				1 XYes 2 No
	with the a or 28s	Funeral Director	10e. Street and Number 7205 PINEY WOOD	S PL	10f. Zij	Code 20707	10g.	Citizen of What Co	•
	death	nera		Was Decedent Ever in U.S Armed Forces?	3. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, White	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene od other than "natural", or Items 23a or 28a-f show avant, I'ra Modical Evarifrat must be notified at		1 Never Married 2 Married 3 Nover Married 4 Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:	1 🗆 Yes		o rican, etc.,	Specify: AS	
15-(- 100	Completed by	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	irk done during most of wor	king 168	o. Kind of Business/l	ndustry
212	filed within Hygiene. other than "	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	OPHTHALM	OLOGIST		MEDICAL	
and	should be filed withir and Mental Hygiene. is marked other than aumatic avant, Ira Mi	Be	17. Father's Name (First, Middle, Last) JAE RYUN CHOE			18. Mother's Nan	ne (First, Middle, Mai HWAN	den Sumame) KIM	
aryl	s 1 and 2 should f Health and Men item 27 is marke other traumatic	P _L	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Address	(Street and Number or Ru			ip Code)
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nore	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	nce of Disposition (Na metery, crematory or o	other place)	21,200	C. Location - City or '	NDRIA VA
Baltimore,	nit. artn orta inju		21. Signature of heral Same License	µvi E. T.	ROPOLITAI 22. Name a	nd Address of FacilityCHZ	The second second		
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	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	cause on each line.	pocardiac		or respiratory arrest.		Interval Between Onset and Death
**	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	1			
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8760,	ate be hysicie the bur	cai	L d.						
Box 68	eath certificate be executed attending physicien and for use as the burial-transit	√Mec	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnan				23d. Date of deli	very
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Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be 4 Homicide determined	et and Number or Ru State)	ral Route Number,				
	s Hospi 24 hour Funer stely fill	Medical	29a. Certifier 1 Cartifying Phys (Check only one)	cian: To the best of my know er: On the basis of examination	vledge, death occurred on and/or investigation	at the time, date and place i, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To thi within To the	Me	29b. Signature and title of certifier	1 2		c. License number	29d.	Date signed (Monti	n, Day, Year)
,			Just 80	J. mo		0-19250		1/19/0	
-	3		JAE S. Chung, 94	npleted cause of death (Item :	23a) (Type, Print) RD Swite ?	06 Lanham	MO 201	106	
	Sta Registi		31. Date filed (Month, Day Year)	32. Registrar's Signa	ille		,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 6:29 PM **CURRY** WILLIAM Η. 2007 160 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR'S HOSPITAL PRINCE GEORGE LANHAM 9. Birthplace (State or Foreign Country) VA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4-8-1914 **Funeral** Months Days Min. Hours 93 579-01-4983 Director STEPHENS_CITY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director Y☐Yes 2☐No MDMONTGOMERY ADELPHI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9200 EDWARDS WAY #1004 S . A . 14. Race - American Indian, 20783-3458 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE SUPERVISOR COMMERCE DEPT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **GEORGE** CURRY TURNER ပ **EMMA** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY G. CURRY--WIFE 9200 EDWARDS WAY #1004 ADELPHI, MD 20783-3458 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State LINCOLN CEMETERY 7-25-07 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD, MD 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 21. Signature of Euneral Service Licensee WASH., DC 20002-5236 524 - 8TH ST., N. E. not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PSI Two weeks /Medical Due to (or as a consequence of): Examiner ebenouscular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine bunal-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 No Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t e Hospital or Attending | 24 hours after death. e Funeral Director: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

A (10)

State Registrar FOZIA ABDULWAHABE N. D. SIIB GOOD LICK ROAD

Date filed (Month, Day, Year)

JUL 2 0 2007

Same D. Spieler

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

552500

State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** COOK 50 0544 ALFRED /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 220-34-3207 Director 69 1938 MARYLÁND Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. tnside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No PRINCE GEORGE'S SEAT PLEASANT Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 70TH PLACE 20743 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filled within 72 hours after Heelth and Mental Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: Specify: ٥ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WARE HOUSMAN PRIVATE 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IRVING COOK ALICE P. JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 70TH PLACE SEAT PLEASANT, MARYLAND MARY A. COOK/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō = 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of important: If any injury or 4 □Donation 5 □ Other (Specify) RIVERDALE CREMATORY 17/9/2007 RIVERDALE, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit 12606 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? δ 99 3 Probably 4 Donknown cate has been signage 2 should b 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 2 No 1 Yes 25. Was case referred to medic examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending Injury investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 24 hours a Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 47867 JULY 18, 2007 30. Name and address of pe pleted cause of death (Item 23a) (Type, Print) Randolph Rd # 216, ROCKVILLE, MD. 20852 0 MD. 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 11:25A Alvis Wayman Caliman 2007 Ju1v/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Holy Cross Hospital Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. Months Days 1 XM 2 ☐ F Director 442-14-3375 86 Jan. 9, 1921 Kansas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov notified at 1 ☑ Yes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 1639 Myrtle St., 20012 United States NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married African 1 ☐ Yes 2 文 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) na most of workina Psychologist/Civil Rights Elementary/Secondary (0-12) College (1-4or 5+) 10 Advisor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fi Guy Caliman Lemon Taliaferro 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun David M. Caliman/Grandson 2002 Lakewood St., Suitland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee's Crematory 7/23/2007 4 □ Donation 5 □ Other (Specify) Clinton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carre (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNeumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit FAILURE ACUTE PENAL Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Hunknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed? Yes 2 No has page 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manger of Death (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury 1 🔲 Yes 2 □ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. or Attending Physician: To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

filed within 72 hours after

Saltimore, Maryland 21215-0036

Box 68760,

Medical State

Registrar

29a. Certifier

(Check only one)

29h Signature and title of certifier

Mary Wright, MD (Hospitalist 30. Name and address of person who completed cause of death Item 23a) (Type, Print) Mary Wright, M.D. 31. Date filed (Month, Day,

2 0 2007

1500 Forest Glen Rd., Silver Spring, MD 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00056108

29d. Date signed (Month, Day, Year)

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ORIGINAL

Registrar

/Medical Examiner The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician the s been signed by the should be detached has Physician:

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permit. Pages 1 and 2 shruld be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is m. rked other than "natural", or Items 23a or no any Injury or other traum; itie event, the Martin or other traum; it event, the Martin or other traum; it event, the Martin or other traum; it event, the Martin or other traum; it is not the martin or other traum; it is

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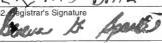
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29 Signature and title of certifier MDDME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A

31. Date filed (Month, Day, Year) State Registrar

18



			1 - For State Registrar	State of Maryla	Ce	rtificate of L			Reg. No.	7 21.79
	Physic	an	1. Decedent's Name (First, Middle, La James Hamilto		r			2. Date of Dea Month	Day	Year 1:30P M
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	Funeral	1	· · · · · · · · · · · · · · · · · · ·	Sex 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hi Hours Mit		Year)	Birthplace (State or Foreign Country)
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	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
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	n the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	hat Country?
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	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in I		Was Decedent of His If Yes, specify Cuba	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
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pu	be filed tal Hygi d other event, tl	Be	17. Father's Name (First, Middle, Las	•			18. Mother's N	ame <i>(First, Middle,</i> etta Smi	Maiden Surname + h	9
yla	12 should be fi n and Mental H is marked otl raumatic ever	2	Robert A. Eas		T					
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship Clare Easter/	(Type. Print) wife	t	ing Address <i>(Street a</i> Cedar L				
	1 and 2 Health tem 27 i	Ĭ	20a. Method of Disposition		Place of Disp	osition (Name of	1	Date	· · · · · · · · · · · · · · · · · · ·	Dity or Town, State
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Ħ	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	. , , , ,	2	idge Cem	s of Facility			ille, MD
ä	permi Depar Impor any Ir		Mexical	(Fley	_ F	'leegle a O Box 16	nd Hei	lfenbein	Funera	al Home, PA
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1	Physician	4	Immediate Cause (Final disease or condition	a. Acute Myo	cardi	al Infar	ction			Onset and Death Acute
1	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		001011			710400
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ά,	execu n and ial-tra	Exal	resulting in death) Last	CDue to (or as a conse	quence of):	11				
68760,	icate be executed physician and s the burial-transit			_d						
	± Dog	Medical	IF FEMALE:							
Вох	leath cel aftendir for use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregr 1☐Live birth 2☐Fet	al death 3	□Ectopic pregnancy			23d. Date Mon	of delivery th Day Year
0	at the deg by the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5[Other (specify)			William	iii Day (eai
Ω.	s that the ned by detac		Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying cause give	n in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
or Vital Records,	uires sign ld be	d by	Parkinson's Di	sease				1 🗆 Y	es 2∐No 3	3 ☐ Probably 4 ☑Unknown
2	w requires been si	Completed						24a. Was a	an 24b. W	/ere autopsy findings available
Re	: The law cate has	omp	-					- autop perfor	sy pr med? de	rior to completion of cause of eath?
ta		Be C	25. Was case referred to medical				26. Place of D	1∐ Yes eath (Check only or		□Yes 2□No n/a
>	d is	To	examiner? 1 XX Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Othe	r: 4 ☐ Nursing	Home 5 X Resid	ence 6 □Othe	r (Specify)
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sio	en or:	cati	2 Accident investigation 3 Suicide 6 Could not be	e 28e Place of injury . At h	nome farm et		′es 2 □ No	20f Looption (C	trant and Mumba	s as Devel Cauta Number
Division	lor Att after de Direct	Certification:	4 ☐ Homicide determined	28e. Place of injury - At I building, etc. (Spec		, cot, ractory, unice		City or Tow	n, State)	r or Rural Route Number,
	o the Hospital or ithin 24 hours after to the Funeral Direct or the Funeral Direct ompletely filled in the funeral or in the funeral or the f			hysician: To the best of my kn						
	thin 24 h	Medical	(Check only 2 Medical Exa	miner: On the basis of examin and manner stated.	ation and/or ir	nvestigation, in my op	oinion, death oc	curred at the time,	date and place, a	nd due to the cause(s)
	当年	Ž	29b. Signature and title of certifier			29c. License	number		29d Date signed	(Month Day, Year)

Registrar

State

Christian E. Jen 31. Date filed (Month, Day, Year) JUL 1 8 2007

ause of death (Item 23a) (Type, Print)

MD; POBox rar's Signature

D14664

690, Denton

07/13/2007

MD 21629

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		For State Registrar	State of Mar			ment of t icate of		, ,	ene	77	21.795
		Decedent's Name (First, Middle, Last	st)					2. Date of Death Month	Day	Year	3. Time of Death
Physici: /Medic		Curtis B. H	lmerson						-	2007	7:56A M
Examin		4a. Facility Name (If not institution, give	e street and number)		4b	. City, Town, o	or Location of Death		4c. County	of Death	
	*	Holy Cross Hosp 5. Social Security Number 6. S		n yrs. last bir	thday) If	Under 1 Year	Silver Spr	ing 8. Date of Birth	M		omery place (State or Foreign
Funeral Director			MM 2□F			onths Days		June 30	Year) 1954	Cou	sh., DC
pu ,		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town	n or Locatio	on					10d. Inside City Limits
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the N 28a-1 notiff	Director	10e. Street and Number	000180		1	Of. Zip Code			g. Citizen of	What Cou	intry?
3a or	۵	7103 Quarry Co	and t				20743				States
ms 2;	Funeral I	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was	Decedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Ameri	can Indian,
after or Ite	T.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give			s,specily.cut Yes 2.5√2rNo		Hican, etc.)	Specia	ck, White,	
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uld be Jenta rked tic ev	To B	Nathaniel E	Emerson					Lessie	Gilli	.am	
2 short and N is ma		19a. Informant's Name/Relationship (Type. Print)	19b	. Mailing A	ddress (Stree	t and Number or Rui	ral Route Number,	City or Town	, State, Zi	ip Code)
and m 27 her tr		Lessie Duncan/	Mother				Ct., Capi				
ges 1 If of H If ite or ot		20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		ry, cremato	ory or other pla	ace)		Oc. Location	,	
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/Medical		disease or condition resulting in death)	Due to (or as a c	onsequence	of):	iomyopa	-	<u> </u>			
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he de the a	ysic	1 Yes 2 No 9 Unknown	4∐Pregnant at tin 9□Unknown	ne of death	5∐ Oti	her (s <i>pecify)</i> _					
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The Is	Completed							autopsy perform 1 Yes 2	ed? Ñ No	prior to co death? 1 ☐ Yes	ompletion of cause of 2 ☐ No
ilan: ertifica	Be C	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only one			
hysic his ce I direc	To E	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Ou	tpatient 3	DOA		ome 5□Reside	nce 6 □Ot	her (Spec	ify)
ing Pl		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		Time of Injury	28c. Inju		28d. Describe how	v injury occu	rred	
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I or A after o Direc	Certification:	4 Homicide determined	building, etc. (Specify)	, sueet,	actory, unice	·	City or Town,		bei Ui ⊓Ui	ar noute Nulliber,
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician of the Funeral Director. After this certificate has been signed by the attending physician of the Funeral director, page 2 should be detached for use as the burial of the funeral director, page 2.			ysician: To the best of a								
the H(in 24 the Fu pletel	edical	(Check only 2 Medical Examone)	niner: On the basis of ex and manner state		IU/UI ITIVEST						
With Control	Σ	29b. Signature and title of certifier	21.17	21		29c. Licen	ise number	29	d. Date sign	ed (Month	n, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jayanti Patel, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910-1484 32. Registrar's Signature

JUL 1 9 2007

D052586

July 16, 2007

			1 - For Stata Registrar	State of	Marylar			nt of H te of L			ental Hyg	iene g. No.	007	24795
	Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		James E. Edv								Ju1y	8	2007	0956 M
	Examir	er	4a. Facility Name (If not institution, give		ber)		4b. City	, Town, or			d 01.4.0		unty of Death	
			1704 Ruston 5. Social Security Number 6. S		7. Age (In yrs.	last hirthday)	If Unde	r 1 Year	If Under		ights 8. Date of Birth			George's
н	Funeral Director		100-44-8955	ŽM 2□F	53	Yrs.	Months		Hours	Min.	Month, Day,	Year)	Cou	place (State or Foreign intry) ew York
			Usual Residence of Decedent				<u> </u>		1		1,000	1,,,,		CW TOTAL
	urylan show	_	10a. State 10b. County		10c. Cit	ry, Town or Lo	cation							10d. Inside City Limits
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_	fter d	Fun	1 Never Married 2 Married	Armed For	ces?				n, Mexican	n, Puerto I	cify Yes or No- Rican, etc.)		Black, White	, etc.
ž	e sul', o	þ	3 ☐ Widowed 4 M Divorced	If Yes, Give Year or Da			1 🗌 Yes	2 🔼 No	Specify:			Sp	pecify: B	lack
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event. I'm Medical Examinar must be multiled at	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	kind of w	ork done d	urina mos	t of workii	ng	16b. Kind	of Business/Ir	ndustry
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Ĕ	permit. Pages Department of I Important: If its any Injury or or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🛣 Donation 5 ☐ Other (Specif			vard Ur			ZOMY	7/1:	3/2007_	W	ash., l	DC
all	apartr aports by Injo		21. Signature of Funeral Service Licer	ishe	ノ <u>ー</u>	22	. Name a	nd Addres	s of Facilit		tewart F			
<u>n</u>	ă∆E a a		18hn ()	marie)	للا						1., NE		., DC	
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VITA	Physician: The law this certificete has brail ral director, page 2 s	Be	25. Was case referred to medical examiner?	Manitali				101		of Death	(Check only on	θ)		
0	D - 0	5	1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatien			4 🗆 140		ne 5 Reside			fy)
_ 0	ding h. After funer	tion	1 Natural 5 ☐ Pending	28a. Date o (Month	, Day Year)	Injury	м	28c. Injury Work	at ? ′es 2 ∐ l		28d. Describe ho	w injury o	ccurred	
UNISION	Atten r deat octor: y the	fica	3 Suicide 6 Could not b	28e. Place	of Injury - At h	ome, farm, str					28f. Location (St	reet and N	lumber or Rur	ral Route Number,
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	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the hiner: On the ba	sis of examina	wledge, death ition and/or in	occurred vestigation	at the tim	e, date an inion, dea	d place, a	and due to the ca	use(s) an ate and pla	d manner as ace, and due	stated. to the cause(s)
	To the To the Confidence of th	Me	29b. Signature and title of certifier				29	c. License	number		25	9d. Date s	igned (Month,	, Day, Year)
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	AC		30. Name and address of person who		-									
	سان ا		Debra Vereen, 31. Date filed (Month, Day, Year)		001 Sil. gistrar's Signa		LLL F	id., 2	∠nd F	Toor	, Suitla	and,	MD 207	U6
	Sta Recistr		JUL 1 9 2007	32. He		iture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Doris Mae Eaton July 14 2007 0125 AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Memorial Hospital Talbot Faston If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 4 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2√2 F 218-34-8642 7.0 May Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Caroline Ridgely 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Hoglot Road 21660 USA 12665 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) waitress restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rueben Buckle Eva Tribbett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12665 Hoglot Road; Ridgely, MD 21660 and Disposition (Name of Date 20c. Location - City or Town, State Percy P. Eaton/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ridgely Cemetery | 7/19/07 Ridgely, MD 21. Signature of Juneral Service Licensee rieggle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): Embolus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se Macroglobulinemia denstrom Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

be executed

Division or Vital Records, P.O. E

Hospital or Attending

To the 1 the

2

the

Medical

State Registrar

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If item 27 is marked other the any Injury or other traumatic event.

Director

Funeral

2

Completed

Be

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filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

Physician/Medical 9

physician and s the burial-trans as for use ed by the a signed t Completed certificate has page 2 s Be P this funeral 24 hours after death. e Funeral Director: After Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy 2 **X**No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

29c. License number

101

29d. Date signed (Month, Day, Year)

Easton, mp 2160

28f. Location (Street and Number or Rural Route Number, City or Town, State)

UVdi 40 31. Date filed (Month, Day, Year)

Street 32. Registrar's Signature

and manner stated.

JUL 1 8 2007



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First. Middle. Last) 2 Date of Death 3. Time of Death Physician 3:40 2007 ROBERT GALL FRANK /Medical County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 ☐ F 274-40-2192 JUNE 1943 OHÍO Director 64 13. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. The Martinal Experiment 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND PRINCE GEORGES LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 12963 Claxton Drive U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 No VIET If Yes, Give Year or Dates: NAM 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. \$ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) PODIATRIST MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CECELIA BERGANSKI FRANK MICHAEL GALL ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12963 CLAXTON DRIVE, LAUREL, 20708 MARIA GALL/SPOUSE MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 5 ☐ Other (Specify) 4 Donation 7/26/2007 | BOONSBORO, MARYLAND BOONSBORO CEMETERY 21. Signature of Senice Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Kelly A. Zimmerman Boonsboro, Maryland 21713 Part1. Ent lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anteriosc **Physician** Lewtic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1∐ Yes 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To uneral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No neral Director: A filled in by the fu 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Cectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 54 ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 3001 31. Date filed (Month, Day; Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Blanche Norris Grantham рм /Medical July 15. 2007 1:55 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3925 Weller Road Silver Spring
If Under 1 Year | If Under Montgomery . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Maryĺand 220-03-5853 Director 86 March 4, 1921 Usual Residence of Decedent the Maryland a or 28a-f show the notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r items 23a o 3925 Weller Road 20906 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1☐ Yes 2☐ No Specify. Specify: White ģ 3 Nidowed 4 Divorced er than "natur the Medical Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 127 is marked other than "traumatic event". Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriet Norris Chase ۵ Edgar Morris Poole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Grantham/ Son 18600 Tanterra Way, Brookeville, Maryland 20833 t: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State July Department o Important: If any Injury or once. Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) 2007 Rockville, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. rdilew 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). O. Box 68760 Physician/Medical as anding gusternas IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? has certificate ha 2 No 1□ Yes 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 XYes 2 No 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) မှ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending Injury 1 Natural 5 Pending after death.

I Director: A
d in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: T/ th- best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: O the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifier Medical (Check only ne) ature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sig July 16, 2007 D00428 momE 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite #304 Ira N. Brecher, M.D DME 2101 Medical Park Drive, Silver Spring, MD 20902 31. Date filed (Month, Day, Year, egistrar's Signature State JUL 18 2007 Registrar

		,	1 - For State of Ma State Registrar	ryland / Dep <i>Ce</i>	rtificate of			iene _{g. No.} 2007	24801
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deatl		3. Time of Death
	/Medic		Mary Alice Grant		T		July	14, 2007	6:56 A ^M
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		-3	Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday	Annapol		8. Date of Birth	Anne Arun	
	Funeral Director		229-20-6308 1 XX 80	Yrs.	Months Days	Hours Min.	(Month, Day, March 22	, 1927 Nor	thplace (State or Foreign ountry) th Carolina
	anyland show id at	٦٢	10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes ※ No
	the M 28a-f outifie	Director	Maryland Anne Arundel 10e. Street and Number	Annapol:	10f. Zip Code		11	Og. Citizen of What Co	ountry?
	with la or la or the r	į	800 Bestgate Road		21401			United Sta	-
	ns 23	Funeral	11 Marital Status 12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (S		14. Race - Ame	erican Indian,
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes ▼▼ ↑ ↑ Yes ↑ ▼ ↑ ↑ Yes or Dates:	o	If Yes, specify Cub 1 ☐ Yes XX No	an, Mexican, Puer Specify:	to Rican, etc.)	Black, Whit	
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ā,	s 1 and Health tem 27 other ti		20a. Method of Disposition		osition (Name of ematory or other pla			20c. Location - City or	
JO.	Pages nent of P ant: If ite ury or o		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Gate of		1	7/2007 S	ilver Spri	ng, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		21. Signature of Funeral Service Licensee	2	22. Name and Addre	ess of Facility J	ohn M. Ta	ylor Funer	ral Home, Inc s, MD 21401
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin						Approximate Interval Between
	Physician /Medical Examiner	3	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a	a consequence of):					Onset and Death
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ds, P	w requires that s been signed b should be deta	by	Part II. Other significant conditions contributing to death but Acre Renal Fails	it not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	oacco use contribute to	o the cause of death? robably 4 ☐Unknown
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ita		BeC	25. Was case referred to medical			26. Place of De	ath (Check only on		2 2 110
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	ng Pł fter tł meral	ü	27. Manner of Death 28a. Date of Injur Natural 5 ☐ Pending (Month, Day		of 28c. Inju Wo	ry at rk?	28d. Describe ho	ow injury occurred	
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Division	al or Ats s after d al Direct ed in by	Certification:	4 ☐ Homicide determined 28e. Place of inju building, etc	ry - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	tural Route Number,
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	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
	(5)		ME 9 MD		DS	518	7	7-1(41	7
	Be		30. Name and address of person who completed cause of de	eath (Item 23a) (Type	, Print) 2001	Medical	Parkway	Annapolis	s, MD 21401
	Sta Registi		31. Date filed (Month, Day, Year) 1 8 2007	r's Signature	Sperke	1.	7. (")		

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2	filed within 72 hours after Hygiene. tther than "natural", or Ite ent, Ita Medical Examina		1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	Jeno Rican, e	stc.)	Specify:	White, etc. BLAC	:K
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	permit. Pages Department of the Important: If ite eny injury or of once.		21. Signature of Funeral Service License	e / //		2. Name and Addre			JENKI			HOME
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2	death death stor: / the f	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28a Place of Injury - At h	ome farm et		Yes 2 No	28f Loc	ation (Street	and Number	or Rural Ro	ute Number
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	To the Hospital or Attending Physicism: The law within 24 hours after death. To the Funaral Director: After this certificete hes completely filled in by the funeral director, page 2.	cai C		icien: To the best of my knower: On the basis of examina								
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	T S S		29b. Signature and title of certifier	Ha. K	/	C) a		10/2		ato aigileu (f	/ A	, . ca)
	10		30. Name and address of person who co	mpleted cause of death /fter	n 23a) (Type	Print)	047 (961	YU	111	101	
10	Col!		CLAYTON STRANC	//		SBURY ROA	AD SUITE	E_130 I	RIVERDA	LE,MAI	RYLANI	20737
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22:10 PM JOSEPH 11 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 265-60-1007 1 M 2□ F GEORGIA Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show at PRINCE GEORGES 1 Yes 2 □ No BOWIE Examiner must be notifled Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DENMARK PLACE 20721 3606 DSA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Black 72 hours 3 ☐ Widowed 4 ☐ Divorced "natural", other traumatic event, the Madical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) MT. Ephraim Baptist PASTOR s 1 and 2 should be filed of Health and Mental Hygi Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES T. GILMORE DOSHIE WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PIACE, BOWIE, MD, 20721 Ethel GILMORE, Pages 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any Injury or of HARMONY MEMORIAI PARK 07-21-2007 LANDOVER, MD 1 Burial 2 □ Cremation 3 □ Removal from 4 Donation 5 Other (Specify) Funeral Service Licens 3015 12thSt NE, D.C. JOHN T. RHLINES FUNERAL HOME Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATORY FAILURE **Physician** 40 MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner certificate be executed the burial-transi and Due to (or as a consequence of) P.O. Box 68760 signed by the attending physician Physician/Medical as b IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, γ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has erforme this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2No 1 ☐ Yes 1 Inpatient ဥ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation within 24 hours after deam.

To the Funeral Director: A 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

31. Date filed (Month, Day, Year) JUL 1 9 2007

(Check only one)

29b. Signature and title of certifier

-IZABETH HARRIS 4940 EASTERN AVENUE M.D. 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

BALTIMORE, MD 21224

11,2007

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se Roberto Go		State of Maryland / Department	of Death Reg. No. 2007 2400
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2 Date of Death 3. Time of Death
edical Exami		Jose Roberto Gomez	July 16, 2007
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min. 09/17/1962 Foreign F.L CountrySalvador
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2121 ould be fill Mental H marked	To B	19a. Informant's Name/Relationship (Type, Print) (wife) 19b. 1	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Lane
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygies with the "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner must be notified at once		Tomasa del Carmen Quintanilla Oxo	on Hill, Maryland, 20745
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit perment of Health and houstal Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funegal Service Licensee	22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, D.C. 20010
and the same		23a. Part I. Enter the disease, or complications that caused the death. Do not de	
Physician /Medical		failure. List only one cause on each line.	Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. MUITIPIE GUISTIOT WOULIDS Due to (or as a consequence of):	
		Sequentially list conditions, b. Due to (or as a consequence of):	
	nine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
be sit	Examiner	events resulting in death) Last Due to (or as a consequence of):	
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	Sa	UNPENDED AMENDED	
50, tte be e nysicia e buria	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
Box 68760, e death certificate be the attending physic ed for use as the bur	an/l	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Month Day Year
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(ecol	, mo		1 V Yes 2 No 1 V Yes 2 No
/ital Rec ysician: The l his certificate l director, page	Be C	25. Was case referred to medical	26.Place of Death (Check only one) patient 3 DOA Other; Other; Nursing Home 5 Residence 6 Other;
· Vit	2	1 Yes 2 No	patient 3 DOA Sure 4 Nursing Home 5 Residence 6 Others ime of Injury 28c. Injury at Work? 28d. Describe how injury occurred
n of \ding Phy. h. After tl	ie E	27. Manner of Death 28a. Date of Injury 28b. Ti 1 Natural 5 Pending Jul 16, 2007 0509	Subject shot
Division of Vital Records, tal or Attending Physician: The law require rs after death. The Thirt of After this certificate has been signify the funeral director, page 2 should be led in by the funeral director, page 2 should be	cati	2 Accident Investigation 28e. Place of Injury - At home, far	m, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) House	749 Audrey Lane, Oxon Hill, MD
Hospi 24 hou Funer	<u>a</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place, and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici; Ton the Funeral Director: After this certificate has been signed by the attending physici are the funeral director, page 2 should be detached for use as the burn.	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)
	Ž	29b. Signature and title of certifier	O.C.M.E. July 17, 2007
		Jord Jet VV	
· R (3)		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature.	₹V
Regi		1111 1 9 2007 Fayer D. Det	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 2:30A M JULY 13, 2007 CHARLES NATHANIEL GREEN, JR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY KENSINGTON NURSING AND REHAB KENSINGTON 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** XX M 2□ F Yrs. 15, 1932 WASHINGTON, DC AUG. Director 577 46 9694 74 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location itiem 27 is marked only than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be mailted at 1 ☐ Yes 2√XNo SILVER SPRING Director MD MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 3620 GLENEAGLES DRIVE #2F 20906 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married XX Married YXYes 2 □ No (K) Yes 2 1110 If Yes, Give Year or Dates: 1952-54 1 ☐ Yes XX No Specify: Specify: BLACK by 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) VA MEDICAL CENTER DRIVER 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental F 7 Is marked ot ALICE FOUNTAIN CHARLES GREEN, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum QDC8. SILVER SPRING, MD 20906 3620 GLENEAGLES DR. #2F DELORES GREEN / SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEM. 07/23/2007 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ATHERSCLEROTIC CARDIOVASCULAR DISESE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Be Completed by Physician/Medical as the b IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Year Month Day Ö in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown DIABETES, HYPERTENSION, CHRONIC OBSTRUCTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PULMONARY DISEASE page 2 s autopsy performed? 1□ Yes XX No 1 ☐ Yes 2 ☐ No ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: XXNursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes XX No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending XX Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. moletely (Check only one) 24 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Chowdly, mp 8 JULY 17, 2007 D43121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wo BURTONSVILLE, MD 20866 15216 DINO DRIVE NURUL CHOWDHURY, M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 1 9 2007

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

32. Registrar's Signature

07-05555 James R. Hines

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar Certificate of Death	Reg. I	No.
Physician/ Medical Examiner	Oecedent's Name (First, Middle,Last)	2. Date of Oeath Month Da July 19, 2007	av Year 1995
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc Prince George's County Hospital Cheverly		4c. County of Oeath Prince George's
Funeral Director		f Under 24Hrs. 8. Oate of Birth(N	MM/DD/YYYY) 9. Birthplace (State or Foreign North Country) Carolina
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
ryland a-f show d once.	MD ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code	100	1 Yes 2 No Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	1803 MEADEVILLE CIRCLE 21144	U	.S.A.
er death wi	1 Never Married 2 Married . Armed Forces? If Yes, specify Cuban, Me 1 Yes 2 V No 3 V Widowed 4 Divorced If Yes Give Year	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
hours aft 'natural" Examine	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done 16	Sb. Kind of Business/Industry
5-0036 Tled within 72 hours Hygiene. 4 other than "natur the Medical Exam Completed	9th BUS DRIVER		PRIVATE
1215-1 be filed ental Hyg urked oth vent, the	JOHN HINES	Mother's Name (First, Middle, Maid ANNIE ARRINGTO	N
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 17 is marked other than turnatic event, the Medica To Be Complé		nd Number or Rural Route Number	·
ore, ss I and of Heal If iten	20a. Method of Disposition 1	·	Oc. Location - City or Town, State BRENTWOOD , MARYLAND
Baltimo permit. Page Department of Important:	21. Signature of Funeral Service Licensee 22. Name and Address of I	Facility J. B. JENK ER ROAD LANDOVE	INS FUNERAL HOME R,MARYLAND 20785
Physician /Medical	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, suc failure. List only one cause on each line.	h as cardiac or respiratory arrest,	shock, or heart Approximate interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhyttmia Due to (or as a consequence of):		
red nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	of both atria and	cardionegaly
760, frate be executed physician and the burial - transit	events resulting in death) Last Due to (or as a consequence of): d.		
760, icate be executed physician and the burial - transi	X UNPENDEO AMENDED 19b per inf g8/1 9-4-0/ vt #2-b,27,perME,g8/0, 8/17/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy		COL Data (California
D. Box 68760, the death certificate be by the attending physici ched for use as the buri	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 E	Ectopic pregnancy	23d. Date of delivery Month Day Year
- E > E U	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given		cco use contribute to the cause of death?
of Vital Records, P.O g Physlchan: The law requires that the this certificate has been signed beneral director, page 2 should be detact to Be Completed by In: To Be Completed by In:		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
tal Recc		performe 1 ✓ Yes 2	d? death? No 1 ✔ Yes 2 No
Vital F yslclan: his certifi director,	examiner? Hospital: A provided to FR Outstand a Don Other	Death (Check only one) er: Nursing Home 5 Res	sidence 6 Other:
n of Vir	27. Manner of Oeath 28a. Date of Injury (Month, Day, Year) 1	Work? 28d. Describe how	
isio Atten r deat ector by the	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office buildi	Amount	et and Number or Rural Route Number, City
Divi	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a		
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, decard and manner stated. 29b. Signature and little of certifier 29c. License nu	ath occurred at the time, date and	
	O.C.M.E	_	uly 20, 2007
	30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201	
State Registrar	31. Oate filed (Month, Day, Year) 32. Registrar's Signar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** July 18, 2007 Nancy Lee Haupt 1:35 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 431 George Street Washington Hagerstown 8. Date of Birth (Month, Day, Yea Apr. 10, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** , 1939 Pennsylvania 1 □ M 2 🗓 F Months Days Hours Min. 220-38-0347 68 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County if Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 431 George Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed by lf Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Jesse Cook Mary Virginia Gordon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha K. Deal/daughter 2918 Philadelphia Ave. Chambersburg, PA 17201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 07/19/07 Beltsville, MD 21. Signature of Funeral Service I Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Endstage Liver Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): nding physician a Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available pnor to completion of cause of death? Was autopsy performed? 24a. Was an certificate 1□ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No I Director: 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a e Funeral I 29a. Certifier 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) July 18, 2007 D55994 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600

31. Date filed (Month, Day, Year) JUL 2 0 2007

Bayestrar's Signature

32.

Lisa Higginbotham, M.D. 11110 Medical Campus Rd. #143 Hagerstown, MD 21742

DHMH 17 Rev 1/2001

State

Registrar

		•	For State Ragistrar	State of Ma		artment of H <i>rtificate of L</i>			ene2 (7	24.003
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
H	Physici /Medic		Doris Virginia H	ORINE				July	22 2007	1650 M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Deat	h
			309 North Locust	Street			erstown		Washir	igton
Т	Funeral		5. Social Security Number 6. Se	_	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) Co	hplace (State or Foreign juntry)
	Director		215-26-1444	□M 2XF	76 Yrs.			Aug. 4 1	930 Mar	yland
	pu &	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	hours after death with the Maryland turel', or Items 23a or 28a-f show at Examiner mast be notilised at	ሯ								11√2 Yes 2 □ No
	189-1	Director	Maryland Washin	gton	над	10f. Zip Code		10	g. Citizen of What Co	nuntry?
	with t	급		_			7.4.0	10		on in y i
	8 23	Funeral	309 North Locust	Street 12. Was Decedent E	vor in II C 12		740	pecify Ves or No-	USA 14. Race - Ame	nican Indian.
	ltern Lern	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		Was Decedent of H. If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, Whit	
36	rs aff	by F	3 ⊈ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	'	1 ☐ Yes 2 No	Specify:		Specify: V	Nhite
5-003	"naturel", o	ed	15. Decedent's Ed		16a. Dece	edent's Usual Occupa	ation	1	6b. Kind of Business	/Industry
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212	yiene.	E	8	0		smetologi	st		Beauty Sa	1on
ğ	il Hygi other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
<u>a</u>	should be od Mental marked c	ToB	James Riley Fren	ch			Carrie	Catherin	e Toms	
aryland	2 shou and N is mai		19a. Informant's Name/Relationship (19b. Mail	ing Address (Street	and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)
Σ	s 1 and 2 should f Heelth and Men Item 27 is marke othar traumatic		Arlington C. Hor	ine, II- S	on 311	North Lo	cust Stre	eet, Hage	rstown, Ma	aryland 2174
altimore,	of Hero		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place	ca)	Date 2	0c. Location - City or	Town, State
٤	permit. Pages Department of Important: If it eny injury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	en Cemete		5/07 н	agerstown,	Maryland
Ħ	mit.		21. Signature of Funeral Service Licen	see					neral Home	
m	F F F G		Fred Es	estal		415 E. Wi	lson Blvd	l. Hagers	town, Md.	21740
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused	he death. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	A	ruto P	ospiveto	my to	ulue		Onset and Death
The second	/Medical		resulting in death)	a. Due to (or as a	consequence of):	2-11-11				(1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,
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	cuted	Examiner	Cause (Disease or injury that initiated events	c. H.	1 perte	nsien				years
o	sicien end burial-transit		resulting in death) Last	Due to (or as a	comma quence of):	•	end S	1-00		
8760	cate be executed physicien end the burial-transit	dicai	•	d	men	· Car	CLIC	stuge.		geens
9		Jed	IF FEMALE:							3
Box	res that the death certifi igned by the attending be detached for use at	by Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		☐Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
	ed fo	SCI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at i 9□ Unknown	me of death 5	Other (specify)			W.Gran	Day (Sai
0	The law requires that the tite hes been signed by the bage 2 should be detache	Phy	9 Unknown				1.0.41	22a Did tab	anne una anntributa t	o the cause of death?
Ś	th se the digner	þ	Part II. Other significant conditions of	onthouting to death ou	t not resulting in the	underlying cause giv	en in Part I.			robably 4 Unknown
Records,	w requir been si should	Completed	\ <u></u>					10,10	s 20110 VII.	
ပ္	law i es b	ple						24a. Was ar autopsy	prior to	utopsy findings available completion of cause of
<u> </u>		50						perform		s 2□100
Vital	Physician: The lav this certificate hes ral director, page 2	Be	25. Was case referred to medical examiner?					ith (Check only one	9)	
Ž	hysic his ca il dire	ု	1 ☐ Yes 2 ☐ No		nt 2 ER/Outpatie		4 Nursing H		nce 6 Other (Spe	ecify)
Division of	ng P fter t inera	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor		28d. Describe ho	w injury occurred	
<u>s</u>	Attending in death.	cati	2 ☐ Accident investigation				Yes 2 □No			
Ξ̈́	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, s . <i>(Specify)</i>	treet, factory, office		City or Town	eet and Number or F , State)	lural Houle Number,
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	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edicai		niner: On the basis of	examination and/or					
	To the I	Med	29b. Signature and title of certifier	and manner sta	eu.	29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)
	5 <u>3</u> 6 8		255. digital and title of certifier	W.		MACA	(E) 131		71231	2007
	AD					11/100			1 1	
	11		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	Print)	W Y	Mon	Spurt n	W 21795
	C.	240	31. Date filed (Month, Day, Year)		r's Signature	-00(1				
	St Regist	ate rar	JUL 242		19. 1	land of				
			A 60 1/2 W	The state of the s	- A	And the State of Stat				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3, Time of Death Day 15, 2007 7:13A HUFFER JULY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Yea Nov. 28, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Year) 1 □ M 2**X**□ F Days 579-52-9296 86 1920 Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 TXNo Maryland Frederick Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11804 Warner Road 21757 USA 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Blankenberg Katharina Kraeha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Peter Huffer/Son 2915 Duval Road, Burtonsville, MD 20866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State July 17, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 | Alexandria, Virginia 21. Signature of Funeral Sarvice License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring MD 20901 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Immediate Cause (Final Cardi vas even 4 thurse leron disease or condition resulting in death) Due to (or as a consequence of) Due to (or se a consequence or, Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

the death certificate be executed

Division or Vital Records, P.O. Box 68760.

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is rr any Injury or other traum once.

Physician

/Medical

Examiner

Funeral

Director

show

ms 23a or 28a-f shor must be notified at

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

2 should be filed within 72 hours after n and Mental Hygiene. Is marked other than "natural", or ite

3altimore, Maryland 21215-0036

Directo

Funeral

9

Completed

death with the Maryland

igned by the attending physician and be detached for use as the bunal-transit al or Attending Paffer death.
I Director: Affer I din by the funers

has

Examine

Physician/Medical

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Completed

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Certification:

Medical

29b. Signature and title of certifier

31. Date filed (Month

Acho

Sequentially list conditions, many, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events souther in death). resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🐔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Wordshum, ud 21798

To the Hospital of within 24 hours at To the Funeral D

Registrar

Md 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND#8perFH7/18/07, EMW, MbCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 3:15 p^M July 15, 2007 Lynn Ann Hines /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18001 Marden Lane Sandy Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Montgomery Social Security Number (In yrs. last birthday, **Funeral** Yeal)957 1 ☐ M 2 🛛 F 50 Director 220-60-5688 9 2007 France March Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Sandy Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other fraumatic event, the Medical Examiner must be no once. 18001 Marden Lane 20860-0125 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Retailing</u> Financial Controller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William J. Follen Ann Hogan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18001 Marden Lane, Sandy Spring, MD 20860-0125 John Hines/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 17,2007 Alexandria, VA 21. Signard)e of Foneral Ser lice Licensee 22. Name and Address of Facility Simple Tribute MD 20852 1040 Rockville Pike, Rockville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Liver Failure Days **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Cholangiocarcinoma with Hepatic Metastases 11 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1☐ Yes 2☐ No 9☐ Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2□ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

> uds

ATTENDING

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D34740

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

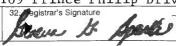
29d. Date signed (Month, Day, Year)

July 17, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Fields, MD 18109 Prince Philip Drive, Olney, MD 20832

31. Date filed (Month, Day, Year) JUL 18 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15 Dorothy R. Hay 2007 July

7. Age (In yrs. last birthday)

10c. City, Town or Location

88

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:

College (1-4or 5+)

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

10f. Zip Code

1 ☐ Yes 2 No

16a. Decedent's Usual Occupation

Annapolis

Annapolis

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

(Give kind of work done during most of working life. DO NOT use retired)

Waitress

21409

8. Date of Birth (Month, Day, Ye June 18,

18. Mother's Name (First, Middle, Maiden Surname)

Sarah F. Gray

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3. Time of Death

РМ

6:55

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐Yes 2 No

Maine

White

Dav

4c. County of Death

10g. Citizen of What Country?

Specify.

16b. Kind of Business/Industry

Restaurant

U.S.A.

14. Race - American Indian,

Black, White, etc.

Year) 1919

Anne Arundel

Physician /Medical Examiner

4a. Facilify Name (If not institution, give street and number)

10b. County

5. Social Security Number

006-14-6434

10a. State

Director

Funeral

þ

Completed

Be

2

Maryland

11. Marital Status

10e. Street and Number

Usual Residence of Decedent

1 Never Married 2XXMarried

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

Frank Reynolds

19a. Informant's Name/Relationship (Type. Print)

12 17. Father's Name (First, Middle, Last)

Anne Arundel Medical Center

6 Sex

Anne Arundel

570 Bellerive Drive, Apt. 143

15. Decedent's Education (Specify only highest grade completed)

1 □ M 2 XF

Funeral Director with the Maryland

items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyghene.

ant: If them 27 Is marked other than "natural", or items 23, and it it them traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must Baltimore, Maryland 21215-0036 permit. Pages 1 and 2: Department of Health as Important: If Item 27 Is any Injury or other trau once.

Physician /Medical Examiner he law requires that the death certificate be executed

attending physician and for use as the burial-tra this

Division or Vital Records, P.O. Box 68760

or Attending Physician;

the Hospital

Walter F. Hay/husband 570 Bellerive Drive, Apt. 143, Annapolis, MD 21409 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vets. Cemetery 7/20/2007 Crownsville, Maryland 4 Donation 5 Dother (Specify) 21. Signature 22. Name and Address of Facility John M. Taylor Funeral Home 77 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 kg 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 21. LNO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 □N0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient ပ 2 ER/Outpatient 3 DOA 27. Man er of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury (Month, Day Year) 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exa iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2101 P M **JOHN** HARRIS, JR 07-17-2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HOSPITAL CENTER Prince George's Cheverly If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 25,1943 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days **Funeral** Hours 1 M 2 □ F Washington, DC 578-60-7696 63 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 MYes 2 □ No D.C. Director Washington 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 23a or inst be n 20019 4811 Minnesota Avenue, N.E. #202 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 1 ☐ Yes Ž No Baltimore, Maryland 21215-0036 Specify: Specify: **Black** þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than Self-employed Shoe Shine Man permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any Injury or other traumatic event, the once. 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Lee John Harris, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4811 Minnesota Ave., NE #202 Wash., DC 20019 Levestine Young/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State 07-24-2007 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cedar Hill FH 4111 PA Ave. Suitland, Md. 20746 Mary Hedgman M013 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOMYOPATHY /Medical Due to (or as a consequence of): **Examiner** CORONARY DISEASE Sequentially list conditions, learny, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner alor Attending Physician: The law requires that the death certificate be executed after death.

Director; After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed I funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be exammer? 1 ☑ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital of within 24 hours at To the Funeral D

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 2 al 11 ype, Print) 3001 Hospital Drive HECTOR COLLISON

29c Picense number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

July 18, 2007

Cheverly, Maryland 20785

and manner stated

07-05392 Grace Hicks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Re	For State	Certino	cate of Death			Reg. No.		1 Cm 1 /6/ 4
	Decedent's Name (First, Middle,Last GRACE HICKS				2. Date of Month July 14	, 2007	Year	3. Time of Death 1348 hrs
4.	a. Facility Name (if not institution, give Prince George's Hospital (4b. City, Tow Cheverl	n, or Location of De y		Prine	unty of Death ce Ge or ge'	
Director	522-24-2647 6. Se	7. Age (In yrs. last bi				f Birth(MM/DD/ 11 1919	(YYY) 9. Birth Fareigr Cou	nplace (State or OKLAHOMA ntry)
ans we		George's Capit	tol Heights				10	10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at ance.	0e. Street and Number 2010 Grovewood Di	rive	10f. Zip Co 207			10g. Citizen U . S	of What Coun	try?
or items must be runera		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 🗽	No specify:	erto Rican, etc.	A Spe	White, etc. African ecify:	an Indian, Black, American
Baltimore, MD 21215-0036 permit. Pages i and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	Iy highest grade completed) College (1-4 or 5+) 5-+	n. Decedent's Usual Oo during most of workin Teach	g life. DO NOT use	retired)	Gov	of Business/Ir	8
21215-0 ould be filed w Mental Hygic marked othe tevent, the N TO Be Co	7. Father's Name (First, Middle, Last) William A. Crain				•	Alexand		
MD 21 d 2 should th and Mee n 27 is man ummatic ev	9a. Informant's Name/Relationship (T Paula Wilson/Da	THE PROPERTY OF THE PROPERTY O	9b. Mailing Address (9017 Armen			-		
Baltimore, Permit. Pages 1 and Department of Healt Important: If item nijury or other tran	0a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State 20b. Place	e of Disposition (Name atory or other place) eterans Ce		Date / 20 / 2001		etion - City or cenham,	Town, State Maryland
Balti permit. Departm Imports injury o	1. Signature of Funeral Service Licen	ge //	22. Name and Ad	dress of Facility ndover Ro	-			al Home 1 20785
/Medical	3a. Part I. Enter the disease, or comp failure. List only one cause on ea mmediate Cause (Final disease a.	ications that caused the death. Do not hine. Hypertensive Atherosclerof	not enter the mode of d	yıng, such as cardi	ac or respirator	y arrest, shock,	or heart	Approximate Interval Between Onset and Death
		Due to (or as a consequence of):						
m iner	f any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated	Due to (or as a consequence of): Due to (or as a consequence of):						
	d.			·	-			
760, icate be exect by physician and the burial - tr	UNPENDED F FEMALE:	AMENDED	N/			234 D	ate of delivery	
lox 68' leath certiff eath certiff eath certiff for use as // sician	ab. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown	23c. If yes, outcome of pregnand 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 5 Other (Specify		egnancy			ay Year
signed by the defacthed by the detached cd by Phy	Part II. Other significant conditions Dementia, diabetes	contributing to death but not result	ing in the underlying ca	ause given in Part I.		_		the cause of death? ably 4 Unknown
Division of Vital Records, let or Attending Physician: The law requires rafter cath. a Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed					_	Was an autopsy performed?		topsy findings available ompletion of cause of
tal Recions: The certificate ector, page	25. Was case referred to medical		26.	Place of Death (Ch	eck only one)			
FVIC Physici r this cal dire	1 ✓ Yes 2 No	lospital: 1 Inpatient 2 ✔ ER/			ursing Home			;
tending Ph ceath. ctor: After t the funeral	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigati	Jul (Month, Day Year) 13	30 hrs	c. Injury at Work? Yes 2 ✓ No	Subject			
Division o spiral or Artending rour after ceath. Till d in by the fund Certification:	3 Suicide 6 Could not determine		, farm, street, factory, of	ffice building, etc.	or To	ion (Street and wn, State) vewood Drive		ral Route Number, City
Division To the Hospital or Attend within 24 hours after ceath To the Funeral Director: completely filled in by the Medical Certification	29a. Certifier 1 Certifying Physici Check only 2 Medical Examine	 an: To the best of my knowledge, d On the basis of examination and/or and manner stated. 	leath occurred at the tir r investigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as state and due to the	e cause(s)
10 2	29b. Signature and title of certifier Joy L	Janu	10	D.C.M.E.			e signed <i>(Mor</i> 5, 2007	nth, Day, Year)
4	30. Name and address of person hho Tasha Greenberg MD /	completed cause of Feath (Item 23a Assistant Medical Examine		eet, Baltimore,	MD 21201			
State ³ Registrar	31. Date filed 131th, 2a (Ye2) 007	2. Registrar's Signature	perte					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** Frances Helton Hillman July 2007 0238 16, /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1212 Palmer Road Prince George's Fort Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-23-1945 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F 226-62-6367 Virginia Director 61 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner cost be notified at 1 X Yes 2 ☐ No Maryland Prince George's Directo Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 1212 Palmer Road 20744 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 M Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Assignment Administrator Verizon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be of Health and Mental H litem 27 Is marked ot r other traumatic even William Helton Agnes Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Palmer Road Fort Washington, Maryland, 20744 19a. Informant's Name/Relationship (Type, Print) Tracee J. Hillman/daughter altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition I MIL Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Resurrection Cem. 07-21-2007 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W. II. Bacon Funeral Home, Inc. 21. Signature of Frineral Service Licensee 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ele s Breas Immediate Cause (Final concer. Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter University Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exami resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) the 1 ☐ Yes 2 PNo Ö 9 Unknown 9 Unknown signed by the Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ None 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ŧ 2 1 ☐ Yes 2 ♣No 2 ER/Outpatient 3 DOA

After Hospitel or Attending death. Director: within 24 hours a the 10

au 31. Date filed (Month, Dey, Year) State JUL 1 9 2007 Registrar

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifie

4 - Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

Certification:

Medica

SNO M.D 32. Registrar's Sign

Rouge

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

and manner stated

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Postifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

46585

10905 Fort Washington Road Suite

Fort Washington, Maryland,

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Del), Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** W 0 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Hospice House Harwood If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Y Oct. 22, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 □ F 452-50-1795 71 Texas Oct. 1935 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show at Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or aminer must be 213 Somerset Bay Drive Apt. # 103 21061 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of nent of Heatth and Mental Hygiene. unt: If tem 27 Is marked other than "natural", or tee uny or other traumatic event, the Medical Examiner ury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Johnson Samuel Jackson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 Janette D. Jackson/Wife 213 Somerset Bay Drive Apt. 103 Glen Burnie, MD July 18, 2007 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie 21. Signature of Ineral Service Severna Park Funeral H Severna Park, MD 21146 P.A. Hwy. 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 □Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Tyes 2 No 3 Probably 4 □Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 2 No 1∐ Yes 1 TYes director, 25. Was case referred to medical examiner? MANDRIN Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes 1 Inpatient ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: HOUSE After 1 Natural (Month, Day Year) Injury To the Hosping. Within 24 hours after death. To the Funeral Director: After a completely filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Date signed (Month, Day, Year) 10

Registrar
DHMH 17 Rev 1/2001

State

41 164

455

Name and address of person

31. Date filed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

1 9 2007)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stata
Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 7/17/2007 John Steve Janny 11:15 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis Elder Care Anne Arundel Severna Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 15 M 2□ F 82 Yrs. 195-12-7097 10/3/1924 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts filed within 72 hours after death with the Marylan Hygene. Hygene. or them 23a or 28a-fehowen, if a Meulsel Exercites must be notified at 1 Yes 2 No MD Anne Arundel Odenton Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 544 Bruce Ave. 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

RXXYes 2 □ No 1943—
If Yes, Give Year or Dates: 1964 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 M/SGT US Army 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other treumatic event 900.8. 18. Mother's Name (First, Middle, Maiden Sumame) Be John Janny Mary Grabarits 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 544 Bruce Ave. Nina P. Janny Wife Odenton, MD 21113 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Rurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 7/31/2007 Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY ONGESTIVE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital To the Hospitel or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٢ 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD, BALTIMORE MA 21236

Registrar

DHMH 17 Rev 1/2001

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C-WALL

JUL 1 9 2007

31. Date filed (Month, Day, Year)

			For State Registrar	State of	Marylan		artment of tificate o				giene Reg. No	711111	24817
	Dhusisi		1. Decedent's Name (First, Middle, Last							2. Date of De	ath Da	ay Year	3. Time of Death
e e	Physici /Medio		JERRY JOSEF		INSON						14	2007	6:14 M
1	Examin	er	4a. Facility Name (If not institution, give		er)		4b. City, Town					County of Deat	-1
	Formul		HOLY CROSS HOSP 5. Social Security Number 6. Se		Age (In yrs. I	ast birthday)	SILVI If Under 1 Yea	ER SPRI		B. Date of Birt		MONTGOM 9. Birt	LRY hplace (State or Poreign
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	the A	Funeral Directo	10e. Street and Number	Dorlos B			10f. Zip Code)			10a. Ci	itizen of What Co	untry?
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	deat	ner	11. Marital Status	12. Was Decede		S. 13.	Vas Decedent of f Yes, specify Co	f Hispanic Ori	igin? (Spec	ify Yes or No		14. Race - Ame Black, White	
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Maryland 21	2 2 2 2		19a. Informant's Name/Relationship (T) EVANGELINE M. JC		IFE		-					or Town, State, 2 IARYLAND	20774
	s 1 and f Health ltsm 27 other to		20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name of natory or other p	Jacol	Da	te	20c. L	ocation - City or	Town, State
altimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				COLN CEN					NTWOOD,	
<u>=</u>	permit. Page Department of Importsnt: If sny Injury or once.		21. Signature of Funeral Service Licens	6e /		22	. Name and Add	Iress of Facili	ty J.	B. JE	INKI	NS FUNE	RAL HOME
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Box 6	death certificate be executed e attending physicien end kd for use as the burial-transii	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. Date of del	ivery
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Vital H	ician: Th certificate rector, pag	e Co	25. Was case referred to medical					00.01	4 D 4 b		2 🗗 No		2X No
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Division		catic	2 Accident Investigation			,		☐Yes 2☐					
Ž	1 th 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At ho , etc. (Specify	me, farm, str	eet, factory, offic	e	28	If Location () City or To			ıral Route Number,
_	Hospitel 24 hours a Funeral I tely filled		29a. Certifier 1 X Certifying Phy	sician: To the b	est of my know	wledge death	occurred at the	time date an	nd place, an	nd due to the	cause/s	s) and manner as	stated
	To the Hospitel within 24 hours a Volume a Completely filled	Medicai	(Check only 2 Medical Examone)	ner: On the bas	is of examinat	tion and/or in	estigation, in m	y opinion, dea	th occurre	at the time,	date an	nd place, and due	to the cause(s)
	withir comp	ž	29b. Signature and title of certifier	N1"	7		29c. Lice	nse number			29d. D	ate signed (Mont	h, Day, Year)
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	Q,		30. Name and address of person who comEHMOODA NAEEM M					SILVER	SPRI	NG, MA	RYL	AND 209	910
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			1 - For State Registrar	State of	Marylan		artmen <i>rtificat</i>				Mental Hy	giene [2401
			1. Decedent's Name (First, Middle, La	ist)	-				,		2. Date of De	ath	V	3. Time of Death
	Physic. /Medi		Suzan Gay Kyriazi	S							Month Jul	y 19, 2	2007	6:00 PM
e de	Examir		4a. Facility Name (If not institution, given		ber)		4b. City,	Town, or	Location	of Death		4c. Cour	nty of Death	
			Springbrook Nursi				1		pring			Mont	gomer	у
ì	Funeral			Sex 7 1 □ M 2 1 F	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	v. Year)	Coul	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		6	/ 115.					Mar. 7	, 1940	Rhode	e″Island
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside City Limits
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	r 288	rec	10e. Street and Number	- J	D II.	VCI bp.	10f. Zip	Code				10g. Citizen o	of What Cour	ntry?
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	deat	by Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U.	.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Sp	ecrfy Yes or No Rican, etc.)	14. R	ace - Americ	
9	or its	F	1 ☐ Never Married 2 🕅 Married	1 ☐Yes 2	? [XNo	1	1 ☐ Yes				nican, etc.)		lack, White,	etc.
ğ	urai',	d b	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:							Spec	Whit	te
2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23e or 28e-f show ent, the Medical Examination must be maillist at	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	dent's Usua kind of wor DO NOT us	l Occupa nk done d	ation <i>luring m</i> os	t of work	ing	16b. Kind of	Business/In	dustry
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0	filad Hygi other		17. Father's Name (First, Middle, Last)		пошеше	INCI		18. Mothe	r's Nam	e (First, Middle	Own Ho		<u> </u>
Maryland 21215-0036	should be nd Mental marked o	To Be	Barney Shaffer								Gauvin		•	
a Z	shou and N man	-	19a. Informant's Name/Relationship (ng Address	(Street a	nd Numbe	or Rur	al Route Numb	er, City or Tow	vn, State, Zip	Code)
Σ	and 2 ealth a n 27 to		Christina Varreccl	nione/da	ughter	127 I	orest	t Ave	enue	Gree	enfield,	IN 46	140	
or e	T = 5 5		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐	70		lace of Dispo	sition (Nam	ne of ther place	9)		Date	20c. Location	n - City or To	own, State
Ĕ	Pages ment of ent: If it ury or o		`4 □Donation 5 □Other (Special		Che	esapeal	ke Cre	emato	ory	07/2	20/07	Beltsv	ille,	MD
Baltimore,	permit. Pages Department of Importent: If i any injury or o	l	21. Signature of Funeral Service Lice	nsee 1		Ğ	Name an	d Addres Home	s of Facilit	atic	n Servi	ce P.	0. Воз	784
9/00,	Physician /Medical Examiner ophsician and prize fransit the prize fransit ophsician and the prize fransit ophsician and the prize fransit open and the prize francs open and the prize francs open and the prize francs open and the prize fr	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that intitated events resulting in death) Last	b. — Due to (or	as a consequence as a c	инпсн оп):	vca.	<i>rd</i> ! (0/	ln:	FONC	7 US		Onset and Death
O. Box og	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		h 2 ∏ Fetal nt at time of de	death 3	Ectopic pre						Date of delive	ery Day Year
T.	law requires that as been signed by 2 should be deta	by Ph	Part II. Other significant conditions of	ontributing to dea	th but not resu	Ilting in the ur	iderlying ca	use give	n in Part I.		23e. Did to	obacco use co	ntribute to th	e cause of death?
ecords,	w require: been sig should b	ed b									101	res 2□No	3 🗆 Prob	ably 4 Unknown
ວ	s bee	Completed									24a. Was	an 24b	. Were auto	psy findings available
ζ	sician: The law s certificate has t lirector, page 2 s	mo										rmed?	prior to cor death?	npletion of cause of
VIIAI	ian: rtifica stor, p	BeC	25. Was case referred to medical						26. Pia e	of Death	1 ☐ Yes n <i>Check only</i> o	2 A No	1 🗌 Yes	2. No
	Physician: r this certific ral director,	10	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2 🗆 l	ER/Outpatient	3□ DO.	A Othe	/		me 5 Resid		ther (Specify	()
5	ding Phys		27. Manner of Death 1	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Bc. Injury Work	at ?		28d. Describe h			
MVISION	or Attend ifter death Director: , in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At ho	me, farm, stre	M et, factory.		es 2 🗆 N		28f. Location (5 City or Tow	Street and Nun vn, State)	nber or Rura.	l Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical Ce	29a. Certifier 1 Certifying Ph	ysician: To the beasiner: On the basiner	is of examinati	wledge, death ion and/or inv	occurred a estigation,	it the time in my op	e, date and inion, deat	d place, h occurr	and due to the ded at the time,	cause(s) and n	manner as st	ated. the cause(s)
	To the	Med	29b. Signature and title of certifier		7		29c.	License	number			29d. Date sign	ed (Month, I	Qay, Year)
_			// 	4 US	312		1	24	15	+7	1	7	19	12007
2)	42		30. Name and address of person no	completed cause	of death (Item	23a) (Type, F	Print)	1 4 4 4	SY	,	- C	1 0	124	214
	Sta	0	31. Date filed (Month, Day, Year)	32.	istrar's Signat	ure		(11)	H	1	ng S	7 >	了一年	7
	Registr		1111 6 6 2	nn7	2	L /								

			State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death	lental Hygien Reg. No	
Ī	Physicia	an	1. Decedent's Name (First, Middle, Last) BETTY A. KINGSBURY		2. Date of Death	ay 2007 Year 7:00 P M
è	/Medic Examin		4a. Facility Name (If not institution, give street and number) PRINCE GEORGE S HOSPITAL	4b. City, Town, or Location of Death CHEVERLY	40	c. County of Death PRINCE GEORGE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year AUGUST 14	
	Director won te		Usual Residence of Decedent 10a. State	ocation	AUGUST 14	10d. Inside City Limits 1√⊋Yes 2□No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ance.	al Director	MD PRINCE GEORGE'S CAPITOL 10e. Street and Number 7001 HASTINGS DRIVE	HEIGHTS 10f. Zip Code 20743	10g. C	X To Z Like X To
020	urs after deat al", or Items 2 xaminer mu	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
1213-0038	within 72 hou ene than "natura the Medical E	Completed	(Specify only highest grade completed) (Giv. life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) POSTAL CLERK	ring	Kind of Business/Industry
and 2	ld be filed ental Hygi ked other ic event, tl	To Be Co	17. Father's Name (First, Middle, Last) JOHN S. BOWIE		e (First, Middle, Maide	en Surname)
Mary	nd 2 shou Ith and M 27 is mar	F	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Rui	ral Route Number, City	or Town, State, Zip Code) LLE, MARYLAND 20721
more,	Pages 1 ar nent of Hea nt: If Item ? iry or othei		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, critical states are considered as a second consistency of the constant of the cons		Date 20c.	Location - City or Town, State
рани	permit. Departn Importa any Inju			22. Name and Address of Facility J. 7474 LANDOVER ROAD		S FUNERAL HOME MARYLAND 20785
0	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	nter the mode of dylun, such as cardiac	respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	<u>.</u>	resulting in death) Due to (or in consequence of): Sequentially list conditions, Due to (or as a consequence of):	to vice	7.	
oʻ	cate be executed oblysician and the burial-transit	Examiner	Sequentially list conditions, if any leaf ing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
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.C. BOX	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ecords, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2☑No 3☐ Probably 4☐Unknown
Heco		Completed			24a. Was an autopsy performed? 1□ Yes 2 図 Ⅰ	
Vital R	siclan: certific irector,	o Be (25. Was case referred to medical examiner? 1 Yes 2 No	Other:	th (Check only one) ome 5 Residence	6 □Other (Specify)
on or	Attending Physiclan: The law r death. cctor: After this certificate has by the funeral director, page 2	-	27. M. ny r of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how in	
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	ccident investigation Could not be determined investigation Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Hospita 24 hours Funera stely fille	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
R	- (6)		30. Name and address of person who completed cause of death (Item 23a) (Typ	USPIFAI De C	Therek	mp 20985
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 1 9 2007 Series 5. April 1.			/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra7-24-07AMEND#'S 20B.20C.PERFH-FAM_CEntificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5:10A M LONG 200 JAMES В. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1∰M 2□F Director 230-22-7704 82 13 1924 ALABAMA NOV. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits jiene. vr than "natural", or items 23a or 28a-f shov the Medic≖l Examiner must be notifled at 1 ¥ Yes 2 □ No Director PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 BRAESIDE DRIVE 20706 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No ARM 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ARMY Maryland 21215-0036 1 ☐ Yes 2 📉 No BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ ENGINEER (DRAFTING) GOVERNMENT other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMPSON JOSEPH G. LONG LUDA ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIA S. LONG/WIFE 8810 BRAESIDE DRIVE LANHAM, MARYLAND 20706 Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State important: If it any injury or o once. FT CINCIP (METERY place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BRENIWOOD, MD LINCOLN CEMETERY 7/19/2007 21. Signature Fune at Servi J. B.JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final **Physician** =disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 000 NAP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Q Q 32 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 2 0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ို 1 Inpatient 2 R/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No al Director: / death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEKBANTILE LANZ STE 135 M.D

MDD 31069

31. Date filed (Month, Day, Year)

32. Registrar's Signature JUL 1 9 2007

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.					
	Physici		1. Decedent's Name (First, Middle, Last) GEORGE EDWARD MANN 2. Date of Death Month Day Year 7 2020 M					
	/Medio Examir Funeral Director		4a. Facility Name (If not institution, give street and number) Memorial Hospital 5. Social Security Number 003-05-1108 4b. City, Town, or Location of Death Easto Talbot If Under 1 Year 1 H Under 24 Hrs. Nonths Days Hours Min. (Month, Day Year) 3-30-1923 9. Birthplace (State or Foreign Country) New Hampshire					
	yland how at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits					
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and San or 28a-f show then 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		MD Caroline Preston $1 \boxtimes Yes 2 \sqcup No$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?					
21215-0036		al Dìr	202 Apple Lane 21655 United States					
		by Funeral Director	11. Marital Status 1					
		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager Civil Service					
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) Henry C. Mann, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Sadie Boardway					
Mary	12 shouh and N	_	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie R Mann/Spouse 202 Apple Lane. Preston. Md 21655					
Baltimore, I	permit. Pages 1 and 2 Department of Health Important; If Item 27 any injury or other tra once,		Natalie R. Mann/Spouse 202 Apple Lane, Preston, Md 21655 20a. Method of Disposition 1					
Balti			21. Signature of Funeral Service Licensee 22. Name and Address of Facility RD 21632 Framptom Funeral Home, PA Federals Burg,					
P.O. Box 68760,	The law requires that the death certificate be executed The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Onset and Death					
		Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown					
	quires that the de in signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown					
al Records,	To the Hospital or Attending Physician: The law requir within 24 hours eiter death. To the Funeral Cirector: After this certificate has been si completely filled in by the funeral director, page 2 should	Completed	24a. Was an autopsy performed? 1					
Division or Vital		Medical Certification: To Be	25. Was case referred to medical examiner? 1					
Divisio			2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 5 Rural Route Number, State Suicide 6 Could not be determined 5 Rural Route Number, State Suicide 6 Rural Route Number, State Suicide 6 Rural Route Number, State Suicide Suic					
			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	To the withing the complex com	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)					
			DM Je Sheeld 00053110 July 21 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Dennis M. Deshields, 219 S. Washington St. Easton, Md. 21601					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

		•	1 - For State Registrer	State of Maryland /	Department of F Certificate of			iene	24322	
	0		Decedent's Name (First, Middle, Last)				2. Date of Deat	h _	3. Time of Death	
	Physicia /Medic		MARY F. M	MIELL			Month	20. 2007	5:35 PM	
	Examin		4a. Fecility Name (If not institution, give st	reet and number)	4b. City, Town, o	or Location of Death	1	4c. County of Death		
			RAVENLOOD LUTHE	RAN VILLAGE	HAGER	STOWN	ł.	WASHIN	16TON	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)	
	Director		220-42-3329	99	Yrs.		Nov. 14		inia	
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits	
	Mary	ō	Virginia Fairfax	Grea	t Falls				1 ☐ Yes 2 X No	
	the 128e	rec	10e. Street and Number	Orca	10f. Zip Code		10	0g. Citizen of What Cou	ntry?	
	3a or	Completed by Funeral Director	1028 Timbercreek T	rail	22066			U.S.A.		
	death		11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of F	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. San principle of the that an "health of the Hygiene" and the Hygiene and interest the modifier at any injury or other traumatic event, I'm Medical Evant and must be modified at once.		1 Never Married 2 Married	1 Yes 27 No	1 ☐ Yes 2 ☐ YNo	an, Mexican, Puerto Specify:	o riican, etc.)	Black, White,		
21215-0036			3 Widowed 4 □ Divorced	Year or Dates:				Specify: Whi	re	
<u>.</u>	"net		15. Decedent's Educa (Specify only highest grade	ition 16 completed)	 Decedent's Usual Occup (Give kind of work done life. DO NOT use retire 	during most of won	king	16b. Kind of Business/In	dustry	
7	within	E C	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Teacher	u)		Education		
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ary	should ind Men s marke umatic		19a. Informant's Name/Relationship (Type	9, Print) 19	9b. Mailing Address (Street	and Number or Ru	ral Route Number,	, City or Town, State, Zi,	Code)	
	ss 1 and 2 of Health a item 27 is		William H. Money/ S	on	1028 Timberca	reek Trai	1, Great	Falls, VA.	22066	
ore	of He of He rothe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	come	of Disposition (Name of stery, crematory or other pla	сө)	Date 2	20c. Location - City or To	own, State	
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Bail	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee	sice	Minnich Ft			atom MD 2	1740	
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			Sequentially list conditions, b.	Artemiosol	isclerate Covorany Anteny Visase					
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Вох	death a atter		23b. Was decedent pregnant in the past 12 mopries? 1 Yes 2 No 9 Unknown Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I.					Month Day Year		
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<u>≥</u>	after after Dire	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	and all addity, and		City or Town			
_	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	Medical Co	29a. Certifier 1 Certifying Physic	cian: To the best of my knowled	lge, death occurred at the tir	me, date and place,	, and due to the ca	ause(s) and manner as s	tated.	
			one)	r: On the basis of examination a and manner stated.	and/or investigation, in my o	opinion, death occur	rred at the time, da	ate and place, and due t	o the cause(s)	
v			29b. Signature and title of certifier	n D	29c. Licens	se number	250 25	9d. Date signed (Month,	Day, Year)	
1			Propert Bull	versonal Mysic	ciare 1-) 072	00/	July 21	200/	
if	-15		30. Name and address of person who com	pleted cause of death (Rem 23a	a) (Type, Print)	MI MI	21716	7	S .	
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signature	· lugersion	11, 110	21/81	^		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 20, 12:45 PM 2007 Lillian May Monninger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 250 Otho Holland Drive Williamsport Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 27, 1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Director 220-46-5208 Maryland Usual Residence of Decedent build be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28e-f show other treumetic event, the Medical Examinar must be notified at 1⊠Yes 2□No Directo Washington Williamsport Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21795 250 Otho Holland Drive USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumetic events. if Health and Menta Item 27 is marked Gordon Dayton Robinson Florence Virginia Murray ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22404 Cave Hill Rd. Smithsburg, Maryland 21783 (Daughter) Carol Hood 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Memorial Park 7-25-07 | Williamsport, Maryland Signature of Funeral Service 22. Name and Address of Facility Osborne Funeral Home P.A. 425 South Conococheague Street Williamsport, Maryland 21795 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Guenous LIKS /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached f 9 Unknown 9 Unknown É signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has page 2 autopsy Phrone certificate 1 Yes 2 No Physiclen: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending Injury 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/20/07 1-0056413 30. Name and address of person who comple -- cause of death (Item 23a) (Type, Print) 3H-2 Sanjay Saxna, MD 1138 Opal Court, Hagerstown, MD 21740 31. Date filed (Month, Day, Year) State 32. Rehistrar's Signature JUL 2 4 2007 Registrar

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit ed by the a detached f within 24 hours after death

To the Funeral Director:
completely filled in by the I

Part II. Other significant conditions of	contributing to death but not res	23e. Did tobacco use contribute to the cause of death?							
					1 ☐ Yes 2 ☐] No 3 ☐ Probably 4 XIUnknown			
					24a. Was an autopsy performed? 1∐ Yes 2X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
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1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify)								
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	280	I. Describe how injury	occurred			
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				8f. Location (Street and Number or Rural Route Number, City or Town, State)				
	nysician: To the best of my kno miner: On the basis of examina					and manner as stated. place, and due to the cause(s)			

29c. License number

D 33332

29d. Date signed (Month. Dav. Year)

July 17, 2007

State Registrar

Medical

Suresh K. Gupta, M.D. 9801 Georgia Ave. Suite2-20 Silver Spring, MD 20902 31. Date filed (Month, Day, Year)

JUL 18 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and tile of certifier



DHMH 17 Rev 1/2001

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 7:00 AM LATHORE JULY 13 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 9204 A Liberty Road Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) July 7, 1937 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F 70 Virginia 226-42-9068 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XXNo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 9204 A Liberty Road United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Mayes 2 1958-59 f Yes, Give 1958-59 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Recycler Automotive 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aubrey Manuel Margaret Grimsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Larry Manuel / Son 9204 A Liberty Rd. Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State $Ju1v \stackrel{Date}{13}$ 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Resthaven Crematory 4 □ Donation 5 □ Other (Specify) 2007 Frederick, Maryland neral Service Licensee 21. Signature of F Restnaven Puneral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

rral", or items 23a or Examiner must be

'natural",

permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical

Directo

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Medical Certification:

Division or Vital Records, P.O. Box 68760,

Immediate Couse (Final disease or condition resulting in death)	a. CARCINOHA OF TH	& LUNG		Onset and Death
Tooling in source	Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequence of):			
that initiated events resulting in death) Last	c			-
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year
art II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
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27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier (Check only one)	hysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place igation, in my opinion, death occu	e, and due to the cause(urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifler		29c. License number	29d. D	ate signed (Month, Day, Year)

State Registrar HEDICAL

32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHITH

31. Date filed (Month, Day, Year) 32. JUL 2 0 2007

JULY 13, 2007

FREDERICK, MD. 21701

HOSPICE OF FREDERICK

516 TRAIL

		State of Maryland / Dep			1ental Hyg	jiene	. 37.2.2.
	_	10910101	ertificate of	Death		leg. No.	1 : 62.0
Physicia	in	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year	3. Time of Death
/Medic	-	Marjorie L. McCracken 4a. Facility Name (If not institution, give street and number)	4b. City. Town.	or Location of Death	July 17	7, 2007 4c. County of Dea	2.00
Examin	er	Heartland Nursing Home	Severna			Anne Arur	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		if Under 24 Hrs.	8. Date of Birth (Month, Day	9. Bir	thplace (State or Foreign
Director		579-14-4228 1□M 2XF 86 Yrs.	monano Dayo	TIOUIS HIAT.	Jan. 14	, 1921 Was	hington, DC
and w t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
Mary -f sho fied a	tor	Maryland Anne Arundel Severna	Park				XXYes 2 □ No
h the or 28a e noti	Director	10e. Street and Number	10f. Zip Code		1	10g. Citizen of What C	ountry?
23a c		715 Benfield Road	21146		U	JSA	
tems	Funeral	Armed Forces?	B. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Tail yial Ind. Z. I.Z. 100000 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland 1s marked other than "natural", or items 23a or 28a-f show reumatic event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify:	ite
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be fill hall H	Be	17. Father's Name (First, Middle, Last)				Maiden Surname)	
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is 1 au of Hea item		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other pla	1	Date	20c. Location - City or	
Page nent c		1 XBurial 2 Cremation 3 Removal from State	,	tery 7/20	/2007 B	Brentwood,	MD
partition c, interpretation of the many particles of the many permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. The number of the many file many many injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Addr	ess of Facility Ro	bert E.	Evans Fune	
205 20						, MD 20715	
-27		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		\ .	or respiratory arr	rest,	Approximate Interval Between Onset and Death
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cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
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To the Hospital or Attending Physician: The law requires that the death certificate thours after death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1	investigation, in my	opinion, death occur	red at the time,	date and place, and du	s stated. e to the cause(s)
To the somply	Me	29b. Signature and title of certifier	29c. Licen	se number	2	29d. Date signed (Mon	th, Day, Year)
		Putt A. 126	DO HOC	25554	2	July 17	2007
00	A	30. Name and address of person who completed cause of death (Item 23a) (Typ 888 Bestaate Rd Suite	e, Print)	napolis	MN:	21401	
Sta Registra		31. Date filed (Month, Day, Year) JUL 1 8 2007 32 legistrar's Signature	houle			- (0 (

DHMH 17 Rev 1/2001

			1- State of Maryland / De State of Maryland / De	partment of Health and I ertificate of Death		iene () ())	24327
	Physici		Decedent's Name (First, Middle, Last)		2. Date of Death Month	1	3. Time of Death
	/Medi		James Preston Meadows		Ju1v	Day Year 17.2007	9:15A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			26566 Three Notch Road	Mechanicsvil	le	St. Ma	rv†s
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Mantha Davis Harris Mi	8. Date of Birth (Month, Day,	9 Rid	nplace (State or Foreign
	Director		219-98-6160 PLM 2 F 30 Yrs		August 2,	1076	Maryland
	land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary	ō	MD St. Mary's Mechan	icsville			1 ☐ Yes 2 ☑ No
	288 1.5.	Je C	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	
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	ms 2	Jer	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sc	pecify Yes or No-	USA 14. Race - Amer	ican Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Itams 23e or 28e-1 show any jirigury or other treumatic event. I're Mickied Frecili at finial be risillified and once.	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
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Maryland	2 sh and Is m			illing Address (Street and Number or Rui			
	and fealth m 27 her t		Amy Meadows/Wife 26	566 Three Notch Roa		icsville,M	D 20659
0	Pages 1 nent of F ant: If its ury or ot		1 X Burial 2 □ Cremation 3 □ Removal from State cemetery, c	rematory or other place)		Oc. Location - City or T	
Ē	t. Pa tmen tent: tjury		`4 □Donation 5 □ Other (Specify) St. Mar	's Newport Cem. 7/	21/07 CI	harlotte H	all,MD
Baltimore,	permi Depa Impo any ir		21. Signatur of Funeral Service Licensee M00945	22. Name and Address of Facility AREHART-ECHOLS FUN	IERAL HOMI	E.P.A.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock or heart allura 1 list only one cause an each line.	211 St. Mary's Ave	. La Plat	ta,MD 2064	6
			Shook, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
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Rox	death certifi e attending j ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the cost 13 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	□Ectopic pregnancy		23d. Date of deliv	ery
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DIVISION	el or Attending F s after death. I Diractor: After d in by the funer	ertification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	теет, гастогу, опісе	City or Town, S	et and Number or Rura State)	al Route Number,
	spite ours seral filled	OL	29a. Certifier Certifying Physician: To the best of my knowledge, dei	ith occurred at the time, date and place	and due to the com-	se(s) and manner as a	tated
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	edical	(Check only one) Medical Exeminer: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date	e and place, and due to	o the cause(s)
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0	n 1.		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			,
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	Stat Registra		31. Date filed (Month, Day, Year) 32. Refistrar's Signature	braste			

			For State Registrar	State of I	Marylan	d / Departme <i>Certifica</i>			Mental H	ygien Reg. N	Brown 40' You'		24626
· ·		9 -	Decedent's Name (First, Middle	e, Last)		1			2. Date of D	eath			3. Time of Death
4	Physici		MARY		N	111-40	R		Month	V 1 3	7 2005	_	1057AM
	/Medio		4a. Facility Name (If not institution	n, give street and aymb	er)	4b. C	ty, Town, or	Location of De	ath	40	. County of De		1
	LAdilli	ie.	FUTURECE	me Ch	OSA	Penue	4	PROL	D		Anne	0/	leunna
25.	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.		der 1 Year	If Under 24 H	rs. 8. Date of B	irth	9. B	Birthplac	e (State or Foreign
	Director		219-38-4553	1 □ M XXXF	6	5 Yrs. Month	ns Days	Hours Mi	1757	1941	M	lary.	land
	P _		Usual Residence of Decedent		40- 01							104	Inside City Limits
	anylar show	L.	10a. State 10b. County			y, Town or Location						100.	1 ☐ Yes 🎗 🛣 No
	Ba-f e	Director		Arunde1	G	ambrills							
	ith th	Die.	10e. Street and Number	,		10f.	Zip Code			10g. C	itizen of What		7
	ath w		965 Fall Circl					1054			US		Indian
	tems	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	S. 13. Was De	cedent of H pecify Cuba	ispanic Origin? in, Mexican, Pu	(Specify Yes or I erto Rican, etc.)	NO-	14. Race - Ar Black, W		
36	s aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 45 ☐ Divorced	If Yes, Give		1 ☐ Yes	2 ½ No	Specify:			Specify:	Wh:	ite
21215-0036	s within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f ehow tra Medical Examinat must be notified at			nt's Education		16a. Decedent's L	Isual Occup	ation		16h	Kind of Busines	ss/Indus	stry
<u>.</u>	c ^ a	Completed	(Specify only highe	st grade completed)		(Give kind of life. DO NO	work done of	during most of w	vorking				,
12	filed within Hygiene. other then "	E C	Elementary/Secondary (0·12)	College (1-4	or 5+)	De1	i Clei	ck			Groc	erv	
9	E E E		17. Father's Name (First, Middle,	Last)					lame (First, Midd	le, Maide			
an	o g as o	To Be	John Joseph Ha	artman Sr.				Margai	et Vest				
Maryland	E B B G	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing Addr	ess (Street	and Number or	Rural Route Num	ber, City	or Town, State	, Zip Co	ode)
	ath a		Doris Hartman	Sister		965 Fall	Circ	le Way	Gambril	ls, 1	MD 2105	4	
Baltimore,	f Heal fem 2 other		20a. Method of Disposition		-	Place of Disposition (Name of	:e)	Date	20c. l	ocation - City	or Town	, State
OL.	Pages nent of int: if it		1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other (5		10	ro Cremat			19/2007	Ba1	timore,	MD	
∄			21. Signature of Funeral Service			22. Name	and Addres	ss of Facility	lardesty	Fun	eral Ho	me,	P.A.
Ba	permit. Departr Importa eny inju		13-4.(h		12 R	idge15	Ave. A	Annapoli	s, M	21401		
			23a. Part1. Enter the disease, p. shock, or heart failure. List	r complications that cau	sed the deat	h. Do not enter the r	node of dyin	ig, such as card	ac or respiratory	arrest.		A	pproximate Iterval Between
); Bl. of tour		shock, or heart failure. List Immediate Cause (Final									0	nset and Death
W.A.	Physician // Medical		disease or condition resulting in death)		as a conseq	MY00	MRI	11/4/	1101-1	910.0	ron	-	21400125
	Examiner			Bue to (o.	45 4 0011304	20/100 01/.							
7	1	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq	uence of):							
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S									
Ć,	exector and and ial-tra	Exa	resulting in death) Last	Due to (or	as a conseq	uence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		L d.									
.89	ficat g phy ss the												
Box	eath certific attending p I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						Ì	23d. Date of	delivery	
m	seath atte	cla	in the past 12 months?	4 Pregnan	n 2∐Feta itattime of d		c pregnancy (specify)	<u> </u>		-	Month	Da	ay Year
0	that the de led by the g detached i	lys	9 Unknown	9□ Unknow	n								
9	res that igned b		Part II. Other significant conditi	ions contributing to deat	th but not res	ulting in the underlying	ng cause grv	en in Part I.	23e. Di	d tobacco	use contribute	to the	cause of death?
Records,	ures sign	d by	RENAL	FAIL	UR	e			_ 1(Yes	2 1 1 1 3 □	Probab	ly 4 □Unknown
Ö	w require been sign	Completed							24a. W	as an	24b. Were	autops	y findings available
Re	he lav	E							ре	topsy rformed2	death	1?	letion of cause of
व			OF Man ones referred to median					OC Disce of di	1 Yes		lo 1 🗆 Y	'es 21	□ No
Vital	Physician: this certifican ral director.	Be C	25. Was case referred to medica examiner?	Hospital:	ationt O	EB/Output 200	DOA Oth	05	Beath <i>(Check on)</i> g Home 5 ☐ Re		€ □Other (€		
5	Phys rthis ral di	. To	1 Yes 2 10 27 Manner of Death			ER/Outpatient 3 28b. Time of	DOA 28c. Injur		28d. Describ			респу	
E C	ding h. After fune	tlon	1 Natural 5 Pendi	ng 28a. Date of (Month, igation	Day Year)	Injury M	28c. Injur Wor	k? Yes 2∐No			,		
Si	death. ctor; A the fu	Ica	3 ☐ Suicide 6 ☐ Could	not be 200 Place of	I Injury - At h	ome, farm, street, fac			28f. Location	(Street	and Number or	Rural F	Route Number,
Division	after Dire	Certification:	4 - Homicide determ	mined 200. Flace of building	, etc. (Specia	(y)	,,		City or	rown, Sta	te)		
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral		29a. Certifier 1- Certifyi	ng Physician: To the b	est of my kno	owledge, death occur	red at the tir	me, date and pla	ace, and due to ti	ne causei	s) and manner	as state	ed.
	24 h Fur etely	Medical		Examiner: On the bas and manne	is of examina								
	o the o the omple	Me	29b. Signature and title of certific		1		29c. Licens	e number		29d. C	ate signed (M	onth, Da	y, Year)
	- S - Ö	-	> Into	y A	h	us M	0	463	60	1	Med 1-	7	7007
	100	dr)	30. Name and address of person	who completed cause	of death (Ites	n 23a) (Type Print)		,	1 4	1	71	1	cuf
	1 10	X	Name and address of person	7	Lace	ens 8h	0/1/	TORAN	sHIGH	Wh.	Mille	000	will a Mh
1	17 CH	ate	31. Date filed (Month, Day, Year	32. R	istrar's Signa		-100	10 1-11/1	3111071	2179	fine	ربہ	
	Regist			9 2007	Parlian .	K him	1.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician ELVA** W. **MCPHERSON** JULY 16 2007 11:50 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CROFTON CONVALESCENT & REHABILITATION PRINCE GEORGE'S CROFTON 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 🙀 F DEC 5 1935 MARYLAND 213-58-8826 71 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at PRINCE GEORGE'S MD UPPER MARLBORO 1 X Yes 2 □ No Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with "natural", or items 23a or idical Examiner must be 14109 SPRING BRANCH DRIVE 20772 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 72 hours after 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo BLACK Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10th filed withir Hygiene. than College (1-4or 5+) COUSTODIAN PRIVATE 1 and 2 should be filed w. Health and Mental Hygier IM 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RICHARDSON **JAMES** JOHNSON MARTHA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau CARLA WYNN/DAUGHTER 14109 SPRING BRANCH DR. UPPER MARLBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State RESURRECTION CEMETERY 7/21/2007 CLINTON, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Furreral Service Ligense 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMERS DISEASE **Physician** /Medical Due to (or as a consequence of): **Examiner** ATHEROSCLEROTIC HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed DYSPHAGIA burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: Ise a 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 MUnknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2▼ No 24a. Was an page 2 autopsy 2X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 2 ER/Outpatient 3□ DOA 1 ☐ Yes 1 | Inpatient ဠ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital or within 24 hours aft

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKESH ARORA M.D. 14300 GALLANT FOX LANE SUITE 222 BOWIE, MARYLAND 20715 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2007 Registrar

DHMH 17 Rev 1/2001

			1 _ State	partment of Health and M ertificate of Death	, ,	
	ITE .		Registrar 1. Decedent's Name (First, Middle, Last)	Fillicate of Death	Reg. N 2. Date of Death	3. Time of Death
	Physici /Medi		GEORGE THROM OWENS		JULY 22	ay Year
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
-	Funeral		317 LANAFIELD CIRCLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	BOONSBORO If Under 1 Year If Under 24 Hrs.	8. Date of Birth	WASHINGTON 9. Birthplace (State or Foreign
п	Director		194-34-1265 ^{1⊠M 2□F} 62 Yrs.	Months Days Hours Min.	(Month, Day, Year APRIL 12,	1945 PENNSYLVANIA
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1			10d. Inside City Limits
	Maryl -f sho fied a	tor		BOONSBORO		1 X Yes 2 □ No
	th the or 28a e notii	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	ath wi	ral	317 LANAFIELD CIRCLE	21713		U.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral		 Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify: 	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
21215-0036	72 hou natura ical E		15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16b.	WHITE Kind of Business/Industry
215	within 7 iene. than "r he Med	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of workin . DO NOT use retired)	ig	·
	filed w Hygiel other tl		11 17. Father's Name (<i>First, Middle, Last</i>)	SALES MANAGER	(First, Middle, Maide	NSURANCE COMPANY
lau	lid be lental ked o	To Be	ALBERT M. OWENS SR.	ANNA THRO		n Surname)
Maryland	2 should hand Ment and Ment Is marked aumatic e		19a. Informant's Name/Relationship (Type. Print) 19b. Mai	iling Address (Street and Number or Rural		or Town, State, Zip Code)
	and 2 lealth m 27 I			LANAFIELD CIRCLE,		, MARYLAND 21713
Baltimore,	Pages 1 nent of H ant: If ite ary or ot		TE Buildi 2 Molemation 3 Enternoval non State	rematory or other place)		Location - City or Town, State
Ħ	nit. Pa artme ortant Injury			JRG CREMATORY 7/23/2 22. Name and Address of Facility		THSBURG, MARYLAND
ä	permit. Departr Importa any Inja once.			RAST FUNEDAL HOME		National Pike , Maryland 21713
	et .		23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest,	Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	YOCAVATAL]	Intara	Onset and Death
	/Medical Examiner		Division to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate b.			
	cuted nd ransit	Examiner	if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
30,	oe exe cian ar urial-t	EX	resulting in death) Last Due to (or as a consequence of):			
68760	ficate be executed physician and s the burial-transit	edical	d			
Box (leath certifi attending for use as	In/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery
O. E.	The law requires that the death certi te has been signed by the attending age 2 should be detached for use a	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
<u>a</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobacco	use contribute to the cause of death?
rds	w requires that the d been signed by the should be detached	d by	DIAhetes Mellitus		- 1	2 No 3 Probably 4 Unknown
000	aw red Is bee 2 shou	plete	chronic obstructive only	MONLY CIPARE	24a. Was an	24b. Were autopsy findings available
Vital Records,		Completed	25. Was case referred to medical		autopsy performed? 1□ Yes 2 No	prior to completion of cause of death? o 1 ☐ Yes 2 ☐ No
	> .≌ ⊽	To Be	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (ent 3 □ DOA Other: 4 □ Nursing Home	(Check only one) Residence	6 DOther (Specify)
0	ding Phys h. After this funeral dir		27. Manner of Death 28a. Date of Injury 28b. Time of Month, Day Year Injury Injury		8d. Describe how inju	
<u> </u>	ttendi leath. tor: A the fu	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVISION OF	after of Direct of in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	8f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
		Medical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	th occurred at the time, date and place, ar nvestigation, in my opinion, death occurred	and due to the cause(s	s) and manner as stated. Indicate the state of the state
	To the Within Fo the comple	Mec	and manner stated. 29b. Signature and title of certifier.	29c. License number		ate signed (Month, Day, Year)
8	15		Duy 1. notatas MD	7002 652	-3 7.	111232007
,	10+1		30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)	/) 0	1
	10		Dino J. Delaportas, M.D. 11100 Me	dical Campus Road,	Hagerstow	n, MD 21742
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	for the		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. -2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2007 July 22 7:35 John Coates Palmer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Caroline Home for Hospice Denton If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** Months Days 127.] M 2∏ F Hours Min. 73 1933 Delaware Director 215-36-1837 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Caroline Denton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or other traumatic event, the Medical Examiner must be 21629 214 Kerr Avenue United States of America Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int If item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Soil Services Owner/Operator 12 of Health and Mental Hygi item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Walter Butler Palmer, Sr. Myrtle Rebecca Coates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 214 Kerr Avenue, Denton, Maryland 21629 Margaret K. Palmer Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 DeBurial 2 □ Cremation 3 □ Removal from State 7/28/2007 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery Denton, Maryland 21. Signature of Funeral Service License, 22. Name and Address of Facility Moore Funeral Home, P.A. 600 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SMa **Physician** CC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PICE 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending within 24 hours after death. To the Funeral Director: A Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

OMar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July **Physician** ĭ8, 2007 Fannie Posey 10:50A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 27194 Queen Tree Road Mechanicsville St. Mary's Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 M 2 TxF 215-26-3037 92 January 10,1915 **Director** Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 27194 Queentree Road 20659 USA 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White þ 3K Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver School School permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If Item 27 Is marked other I any Injury or other traumatic event, <u>the any Injury or other traumatic event, the secont of the secont in the secont of the secont in the secont in the secont in the secont in the secont in the secont in the second of t</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosser Mitchell Bertie Wheeler ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27194 Qeentree Rd., Mechanicsville,MD 20659 Dennis Posey/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Park Hill Cemetery 7/23/07 Marbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22. AREHARTEECHOUS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata,MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) C, NOMA RE **Physician** EW MO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown cate has been signed by page 2 should be detacl Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No lospital or Attendil 4 hours after death. Funeral Director: A death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

SHVIN KUMA 31. Date filed (Month, Day, Year) JUL 2 0 2007

au

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL MellIN CT

07-05438

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Eugene Francis Pritchard, Sr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 3. Time of Death Month Day July 16, 2007 Medical Examiner 0045 hrs Eugene Francis Pritchard, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Director Days Hours 365-38-9453 1 X M 2 F 67 CountryTennessee Aug. 25, 1939 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No 28a-f show Maryland Cecil North East must be notified at once. the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country or items 23a or 112 Old Bay View Road <u>United States</u> with Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? ·White, etc. 2 X Married 1 Never Married it Pages I and 2 should be filed within 72 hours after dea frient of Health and Mantal Hygiene.

rant: If item 27 is marked other than "natural". or ite. 1 X Yes 4 Divorced If Yes, Give Year U.S. Widowed Yes 2 X No specify: Specify: Army White 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Com Roofing and Siding Mechanic Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Pritchard Polly Hughes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Wanda Pritchard 112 Old Bay View Wife Road, North East, Maryland_ Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State July rtant: Donation 5 Mayerdale Crematory 2007 Newark, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Crouch Funeral Home South Main Street, North East, Mary1and21901 Approximate Interva 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months 2 Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed ificate has been si r, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 1 🗸 Yes Yes 2 Nο funeral director, 25. Was case referred to medica 26.Place of Death (Check only one Be examiner? Other₄ Nursing Home 5 this Inpatient 2 ✓ ER/Outpatient 3 DOA Residence 6 1 🗸 Yes No 28a. Date of Injury Jul (Month, Day Year) Jul 16, 2007 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject assaulted while driving vehicle 0009 hrs Natural Yes 2 ✔ No Pending

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, hours after death. the To the Funeral Director: è, completely 241

Accident

Suicide

29b. Signature and title of certifier

4 Momicide 29a. Certifier 1

3

Medical

State

Registrar

5+1VA

Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner

(Specify) Local Street

Investigation

determined

6 Could not be

O.C.M.E. OCME July 16, 2007

or Town, State) 835 Nottingham Road, Elkton, MD

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2 0 2007

30. Name and address of person who completed cause of death (Item 23) (Type, Print)

MARK P. LOLOSJEW NORTHWEST HOSPITAL CENTER GO LOSTE N 32. Registrar's Signature

n.D.

D 0061529

29d. Date signed (Month, Day, Year) 12,2007

Francisco Jovney	1	- For State Registrar				artment ertificate	of Health a of Death	nd Ment		Reg	No.	1.7	
Physiciar Medical Examin	4	1. Decedent's Name (Fin	st, Middle,Las	t)	0	uintan	illa		Mor	e of Death oth [7 14, 200	Day Year		ne of Death 07 hrs
		4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center 4b. City, Town, or Location of Death Cheverly									4c. County of D		
Funeral Director		5. Social Security Number 460-99-719	er 6. Se		7. Age (In yrs.		If Under 1 Y	ear If Under ays Hours	1	ate of Birth	(MM/DD/YYYY) 9		
	A SHARE	Usual Residence of Dec 10a. State 10b.	edent		10c. Cit	y, Town or Lo	cation					10d. I	nside City Limits
ith the Maryland 23a or 28a-f show any notified at once.	'n	Maryland P	rince	George'	s Ri	verdal	e					1	Yes 2 X No
Maryla r 28a-f	Director	10e. Street and Number					10f. Zip Code			, i	. Citizen of What		
after death with the Maryland sil", or items 23a or 28a-f she iner must be notified at once		5705 Jeffe	rson S	12. Was Dec	edent Ever in	U.S. 13.	2073 Was Decedent of	Hispanic Orig	gin? (Specify Y	es or No-	14. Race - A	merican Inc	dian, Black,
death or item	Funeral	1 X Never Married		1 Yes	2 X No		f Yes, specify Cut				White, e		
ars after	<u>a</u>	3 Widowed 4		If Yes, Give Year or Dates: nly highest grad		16a. Dece	Yes 2	pation (Give k	kind of work do		Specify: 1 16b. Kind of Busin		у
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itani: If item 27 is marked other than "natural", or other traumatic event, the Medical Examine.	Completed	Elementary/Secondar	y (0-12)	College (1	-4 or 5+)		most of working	ife. DO NOT	use retired)	3 10	Home Im	2501101	mont
21215-0036 und be filed within 7 Mental Hygiene. mayked other than revent, the Medica	Ĕ,	12 17. Father's Name (First	t, Middle, Last)		Pair	iter	18.Mother	's Name (First,	Middle, Ma	Home Impaiden Surname)	prover	nenc
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MD 2. d 2 should lith and M n 27 is m numatic e	٤	19a. Informant's Name/F Douglas H.	Relationship (Quint	o ^{ype, Print)} C anilla-	ousin Blanco						er, City or Town, ${\sf ton, TX}$.ode)
re, N s 1 and s f Health If item er trau		20a. Method of Dispositi		Removal fro			oosition (Name of other place)		Date		20c. Location - Ci	-	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5	Other Specify		G	1/1/1	Heaven 2. Name and Addr		07/21/2	2007	Silver S	Sprin	g, MD
Balt permit. Depart Import injury		21. Signature of Funeral	/lllez_		м009	56	Thibadea 933 Gist	u Morti Avenu	uary Se e. LL.	Silve	er Spring		20910
Physician /Medical		23a. Part I. Enter the dis failure. List only or	sease, or com	olications that ca ach line.	aused the dea	th. Do not ente	er the mode of dyi	ng, such as c	ardiac or respi	ratory arres	st, shock, or heart	App	roximate Interval
Examiner		Immediate Cause (Final or condition resulting in		Multiple Gu						-		-	Death
1		Sequentially list condition		Due to (or as a						_			· ·
	Examiner	if any, leading to immed cause. Enter Underlyin (Disease or injury that in	Cause									-2	
uted nd ransit		events resulting in deat	h) Last d	Due to (or as a	consequence	of):							
O, e be executed ysician and burial - transit	edical	UNPENDED		AMENDED							F-300		
Sox 68760, leath certificate be attending physic for use as the bur		IF FEMALE: 23b. Was decedent preg past 12 months?	nant in the	23c. If yes,	outcome of pro irth	egnancy 2	Fetal death	3 Ectopic	c pregnancy		23d. Date of de Month	elivery Day	Year
Box 6 e death cer the attendi	Physician/M	1 Yes 2 No 9	Unknow		ant at time of	death 5	Other (Specify)						
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Division of Vital Records, tal or Attending Physician: The law requirers after death. The Director: After this certificate has been sided in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to be a should be a second to be a sec		25. Was case referred t	o medical				26.P	ace of Death	(Check only or	Yes 2	No 1	∕ Yes	2 No
Vita hysicia this cer	To Be	examiner? 1 ✓ Yes 2	No			✓ ER/Outpat		Other ₄	Nursing Hom			Other:	
Division of N Hospital or Attending Ph. 24 hours after death. Funeral Director: After the tell filled in by the funeral		27. Manner of Death 1 Natural 5	Pending	28a. Date Jul 14, 2	of Injury Day Year) 2007	28b. Time 0035 hrs	· · · -	Injury at Work Yes 2 ✔	- ISubi	Describe hi ect shot	ow injury occurred	l	
visior or Attend ter death virector: on by the	Certification:	2 Accident 3 Suicide 6	Investiga Could no	28e Plac	e of Injury - A	home, farm, s	treet, factory, offi	ce building, et			treet and Number		
Divis	Certi	4 Homicide	determin	ed (Specify)	Local Str						ate) e Road, Riverda		ld.
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier 1 Certifier one) 2 Med	tifying Physic dical Examine	er:On the basis	of examination	edge, death o n and/or invest	ccurred at the time igation, in my opi	e, date and pla nion, death oc	ace, and due to courred at the t	o the cause ime, date a	e(s) and manner a and place, and due	s stated. e to the cau	se(s)
To COL	Med	29b. Signature and title	of certifier	and manner s	tated.			ense number			29d. Date signed		ay, Year)
		Jon	VX	2)0	1	Jun-	0.	C.M.E.			July 14, 200	/	-
UR		30. Name and address Tasha Greenbe	. (/	Assistant M			11 Penn Stre	et, Baltimo	ore, MD 212	201			
	ate	31. Date filed (Month, D	ay, Year) 2007	32. Re	egistrar's Sign	ature	ジ						
Regist		JUL 1 8) <u>LUU1</u>	Ulalua	<i>)) (</i> ·	ORIGI	NAL						

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July Marvann Rice 17,2007 11:55 am [™] H. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Ingleside Court 2087 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🕱 F Sept. 5, 1954 Director Philadelphia, PA 212-66-9757 52 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglenc. Department of Heath and Mental Hyglenc. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑No Director MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2087 Ingleside Court 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Assistant Manager Sears 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Sheehan William Henry Jr. ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2087 Ingleside Court, Crofton MD. 21114 Sean P. Rice /Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State July 24, 1 Burial 2 Cremation 3 Removal from State Clinton, MD 4 Donation 5 Dother (Specify) Resurrection Cemetery 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Douth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only have use on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 2 XNo 1☐ Yes 1 ☐ Yes 2 2 director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: thin 24 hours a

DHMH 17 Rev 1/2001

State Registrar 29b. Signatu

filed (Month, Day, L 1 9 2007

29d. Date signed (Month, Day, Year)

and manner stated.

			1 - State of Maryland / Department of Health and M Certificate of Death	Reg.	6.031	24937
	Physicia	an	1. Decedent's Name (First, Middle, Last) Max Gustav Rein	2. Dale of Death Month July 1	Day 2007	3. Time of Death 2:45A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home 4b. City, Town, or Location of Death Charlotte Hall	July	4c. County of Death St. Mary	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Sept Usual Residence of Decedent	8. Date of Birth (Month, Day Ye ember 23,	9. Birthg 2017 Cour 1921 Ge	place (State or Foreign htry) Ermany
	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-1 show dicel Examinar must be notified at	rector	10a. State 10b. County 10c. City, Town or Location MD St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code	10a.	Citizen of What Cour	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23a or	rai Di	29449 Charlotte Hall Road 20622		USA	
9036	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Heath and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show or other treumatic event, the Medical Examinat must be notified at	Completed by Funeral Director	11. Marital Slatus 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 □ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	etc.
Baltimore, Maryland 21215-0036	d within 72 h giene. or then "natu	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Transportation Manage	ing	Trucking	dustry
yland	should be filed and Mental Hygis marked other umatic event, il	To Be C	Emanuel Wolfgang Rein Margaret	e (First, Middle, Maid ta Edigka	ufer	
Mar	nd 2 sh alth and 27 ie m r treum		19a. Informant's Name/Relationship (Type, Print) Diana Rein/Daughter 19b. Mailing Address (Street and Number or Aura) 9249 High Banks Drive,			Code)
ore,	Pages 1 and 2 hent of Health a nut: if item 27 ie iry or other trei		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 7 / 2	Date 200	c. Localion - City or To	
3altin	permit. Page Department of Importent: If eny injury or once.		4 Donation 5 Other (Specify) Alleghany County Memorial 21 Signature of Funeral Service Licensee M00945 AREHART-ECHOLS FUN		Allison Pa	ark,PA
Charles 8760,	Physician /Medical Examiner ial-transit	dicai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A OVIC Stonosis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			proximate Interval Between Onset and Death
F 26.	that the death certific ed by the ettending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown		23d. Dale of delive Month	ory Day Year
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tal Rec	iysician: The law iis certificete hes b director, page 2 sl	e Completed	Alzheimer's Dementia. 25. Was case referred to medical 26. Place of Death	24a. Was an autopsy performed 1 Yes 2 X	prior to co death?	psy findings available mpletion of cause of
Division of Vital Records,	× 2 5	ToB	examiner? Yes 2 No	h Check only one one one one one one one one one one	e 6 Other (Specifinjury occurred	v)
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospital within 24 hours a To the Funerel completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, death occurred at the time, date and place, and manner stated.	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier Paul Stauris 29c. License number D45092		Date signed (Month, July 18	0007
	NB7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road Suite 205 Prince 31. Date filed (Month, Day, Year) 111 2 0 2007 32. Registrar's Signature	Frednic	ch Mi	20678
	Sta Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		1,00	- 0 0

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day DAVID С. SHIREY July 22 2007 1735 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1216 Grange Hall Road <u>Centreville</u> Queen Anne Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 2/30/29 214-28-0499 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Queen Anne Centreville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1216 Grange Hall Road 21617 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 No lif Yes, Give 1 51 − 54 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🕱 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Honeywell, Inc. Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Jacob Shirey Mabel Ponesmith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty S. Shirey/Spouse 1216 Grange Hall Road, Centreville, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition txDBurial 2 ☐ Cremation 3 ☐ Removal from State Eastern Sh. Vet. Cem. 07/26/07 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signatur Funeral Service Agent 216 N. Main St., Federalsburg Approximate Interval Between Onset and Death 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrythmia minutes Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aresidence 6 Other (Specify)

Physician /Medical Examiner

be executed

P.O. Box 68760

Division or Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show at

death y

72 hours after

Maryland 21215-0036

Baltimore,

notified

r than "natural", or items 23a or the Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nat any injury or other traumatic event, the Medica once.

Director

Funeral

Completed

Be

and physician the attending use ō the signed by t Completed peen : has this certificate To the Hospital or Attending Physician; within 24 hours after death.

After t

within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician/Medical

2

Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Yes 2 No

27. Manner of Death 1. Natural 5 ☐ Pending investigation 2 Accident

6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert My mc Donald, MD

29c. License number

29d. Date signed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print) 30 Dover Street, Easton, Mcl 21601

State Registrar



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

JUL 20

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3: Time of Death Month Day **Physician** 5NZED MARK 8:06 0 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEDICAL CENTER ARUNDEL ANNE ARUNDEL ANNOPOLIS LNUZ 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12/7/1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Funeral Months Days Hours Min. 1**X** M 2 □ F 50 Kentucky 406-76-9874 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Riva Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21140 USA Items 23a 525 Poplar Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2X If Yes, Give Year or Dates 1 Never Married 2 Married ö 1 ☐ Yes 2 No Specify: White Specify. þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) President Phillips Foods, Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Brooks Lende1 Sneed ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau once. Candace Sneed/ Wife 525 Poplar Drive Riva, Md. 21140 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Mem. Gardens 7/21/2007 Davidsonville, MD. 5 ☐ Other (Specify) 22. Name and Address of Facility Geo. P. Kalas Funeral Home 21. Signature Funeral Service Fen 2973 Solomons Island Rd. Edgewater.MD.21037 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 MIN MYOCAZIAL INFARCION /Medical Due to (or as a consequence of): **Examiner** 10 years ATHUROSCLEROSIS CORONORY Sequentially list conditions, if any, resume to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed YEAR S HYPORCHOLESTEROLEMIA Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death I□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an autopsy perform 2 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 30 DOA မှ 1 Inpatient 2 ER/Outpatient 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral D

completely filled in 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) MD DO05336L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

LUTH ZEVILLE

21093

10755 FALLS RD

's Signature

32. Regist

5. QUEALE

1 8 2007

WILLIAM

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

								Cert	ificate of	Death		Reg. No.	1 1	20041
			1. Decedent's Name	e (First, Middle, La	ist)						2. Date of De		Year	3. Time of Death
	Physicia /Medica		HEL	ENE	STRE	ETER					JULY	15 200		00:11 AM
· ·	Examine		4a Facility Name (II	not institution, giv	ve street and n	umber)				4b. City, Town, o	r Location of Deat	1 4c. County	of Death	
			PRINCE G	EORGE'S	HOSPITA	L				CHEVERLY		PRINCE	GEO	RGE'S
	Funeral Director		5. Social Security N 239-48-4	853	Sex 1□M 2231F	7. Age (In	yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days			th ly, Year) 1933 1	Cou	place (State or Foreign ntry) n Carolina
	and **	1	Usual Residence of 10a. State	10b. County		10	c. City, Tow	n or Loca	ition		7 - 4 - 1777	-		10d. Inside City Limits
aryland 21215-0020 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. r marked other then "naturel; or items 23a or 286-4 show umatic event, the Medical Examiner must be notified at		cto	MD	PRINCE	GEORGE'	S	SEAT	PLEA	SANT					Yes 2□No
		Funeral Director	10e. Street and Nun 614 BIRC		ENUE				10f. Zip Code 20743			U.S.A.		ntry?
020	ours after dea rei', or items Examiner m		11. Marital Status 1 ☐ Never Marrid 3 ☐ Widowed	ed 2 Married 4 Divorced	12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? 212 No ive	r in U,S.		as Decedent of Yes, specify Cul		Specify Yes or No erto Rican, etc.)	Blac	e - Ameri k, White, ; BLA	
2 - -	72 ho	eted	(Spec	15. Decedent's E	ducation ade completed)	16a	. Decede (Give ki	nt's Usual Occu	petion during most of weed)	orking	16b. Kind of Bu	usin es s/Ir	ndustry
121	vithin ne.	To Be Completed by	Elementary/Secon			(1-4or 5+)					•	PRIVA'	יגניו	
N	lled v tygie her ti nt, th	ဒီ	12th 17. Father's Name (Eiret Middle Last	1				HOME MA		ame (First, Middle			- 10
ano	d be f intal H ed of	g	SAM HOPK		,						A HOPKIN		,0)	
چ	should be filed and Mental Hygi marked other imatic event, I	۲	19a, Informant's Na		Type Print)		198	Mailing	Address (Stree		Rural Route Numb		State. Zi	n Code)
æ ≥	and 2 s ealth an n 27 is r	- [STREETE		AND								AND 20743
Baltimore, Maryland 21215-0020	ot ite			osition Cremation 3 [5] Other (Specia			cemete	ry, crema	tion (Name of tory or other place RANS CEI		Date 7/23/200	20c. Location -	-	own, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Fu			11			Name and Addr		J. B.JENI AD LANDO			
	Physician		23a. Part1. Enter the shock, or hear	ne disease or com t failure. List only	aplications that one cause on	caused the each line.	death. Do						1	Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (disease or condition	Final า	нүр	ERTENS	SION						1	
		Jer	resulting in death)		CHR		to (or as a			NARY DIS	SEASE			
- `	executed n and ial-transit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or	nditions, mediate	b		to (or as a							
X 68/60	law requires that the death certificate be executed as been signed by the attending physician and 3.2 should be detached for use as the burial-transit	/Medical	Cause (Disease or that initiated events resulting in death) L		c	Due	to (or as a	conseque	ence of):					
. E	es that the death cer igned by the attendin be detached for use	Pnysician/	Part II. Other signifi	cent conditions	ontributing to	leath but no	ot resulting i	n the und	erlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute 1	o the cause of death?
s, P.C	that the	5									1 🗆	Yes 2⊠No	3 ☐ Pro	obably 4 ☐ Unknown
ecords	aw requires ts been sig 2 should b	Completed by									24a. Was	an autopsy ormed?	a\ co	Vere autopsy findings vailable prior to completion of cause death?
r	Physician: The lav this certificate has ral director, page 2	É									10	Vue all No	1	□Yes 2t No
Z Z	ian: ortifica ctor,	ge C	25. Was case referr examiner?	ed to medical						26. Place of D	eath Check only	one)		
<u>o</u>	Physician: this certificantal director,	0	1 ☐ Yes 2 ☐	Vo		Inpatient	2 19 ER/O	utpatient	3LI DUA		Home 5 ☐ Resi	dence 6 □Oth	er (Speci	fy)
	fter ther		27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigatio		of Injury oth, Day Ye	ar) 28b.	Time of Injury	28c. Inju We M 1	uryat ork?]Yes 2∐No	28d. Describe	how injury occur	red	
DIVISION	al or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Flat	e of Injury - ling, etc. (S	At home, fa	arm, stree	t, factory, office		28f. Location (City or To		er or Rur	al Route Number,
		edical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	niner: On the b						ne, and dile to the curred at the time,			
	To th To th	M	29b. Signature and	title of certifier					29c. Licer	se number	- 0	29d. Date signe	d (Month,	Day, Year)
)	(7)		19/	No	en	-			Do	0591	133	1/50	7	2007
•	6		30. Nam and ad	Sleu M	completed cau	1 2	(Item 23e)	(Type, Pr	- L	countle	Laure L	aurge V	n	20774
I	State Registra		21. Date filed (Mont	0 2007	32.1	Registrar's	Signature .	E.				d		

1 - For State Registrar

ite of Maryland /	Department of	Health and	Mental	Hygiene
	Certificate of	f Death		Reg. No.

2. Date of Death

Day

3. Time of Death

	1. Decedent's Name (First,	Middle, Last)
Physician /Medical	GLORIA	THE
Examiner	4a. Facility Name (If not ins	titution, give s
- A	6615 NORT	HAM RI

Funeral

Director ral", or items 23a or 28a-f shov Examiner must be notified at 'natural', or items

filed within 72 hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number 20748 6615 NORTHAM RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORKER permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) Be MARY HENRY FRANK SPRIGGS ို 19a. Informant's Name/Relationship (Type. Print) 6615 NORTHAM RD. MARY JAMISON/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEM. 7/20/07 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE KIDNEY FAILURE Due to (or as a consequence of): /Medical Examiner DIABETES Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed HYPERTENSION Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ŏ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ DEMENTIA SENILE, Completed page 2 s 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital or 24 hours a 29a. Certifier Medical To the Hos within 24 ho To the Fun completely i 29c. License number 29b. Signature and title of certifier D52741 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 LIVINGSTON RD. FT. WASHINGTON, MD 20744 CAROLINE J. CAINE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 9 2007 Ŋ.

GLORIA THERESA SPRIGGS JULY 14 2007 3:25 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death PRINCE GEORGES 6615 NORTHAM RD. TEMPLE HTLLS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 万 77 6/29/30 MARYLAND 134-24-0690 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TYes 2 No MD PRINCE GEORGES TEMPLE HILLS 10g. Citizen of What Country? U.S.A. 14 Bace - American Indian. Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry HOUSEKEEPING 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TEMPLE HILLS, MD 20748 20c. Location - City or Town, State CLINTON, MD 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 XNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) July 18, 2007

State of Maryland / Department of Health and Mental Hygiene Vincent Louis Thompson 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 20, 2007 0614 hrs ~al Examiner VINCENT LOUIS THOMPSON 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Caroline 25320 Richardson Road Federalsburg 8. Date of Birth (MM/DD/YYYY g. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 215-35-2104 18 Apr.11.1989 Director Country) 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State Yes 2 X No MD Caroline Preston 28a-f show or items 23a or 28a-f shov must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 24165 Mallow Drive 21655 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes White Yes 2 X No specify: Divorced If Yes, Give Year "natural". the Medical Examiner <u>۾</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) it. Pages 1 and 2 should be filed within 72 hour triment of Health and Mental Hygiene. Tant: If item 27 is marked or other fram. Completed College (1-4 or 5+) Elementary/Secondary (0-12) Student Education 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathleen Shanahan Blades Vincent Rodney Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen N. Blades/Mother 24165 Mallow Dr.. Preston, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) 2 Cremation 3 Removal from State Department o Important: Junior Order Cem. 7/25/07 Preston, MD Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licenses Framptom Funeral Home, Federalsburg, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a. Asphyxia by hanging Immediate Cause (Final disease *xaminer* or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Day Year 3 Ectopic pregnancy Month Live birth Fetal death Pregnant at time of death 5 Other (Specify, Yes 2 No 9 Unknown g Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ≥ 1 Yes 2 ✔ No 3 Probably 4 Unknown ۵ Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed' ✓ Yes 2 1 🗸 Yes No certificate 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Hospital: 1 examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA Inpatient 2 his ဥ 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury After 27. Manner of Death Certification: Subject hanged self FOUND: Natural 1 Yes 2 ✔ No e Funeral Director: / Pending Jul 20, 2007 0600 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) 25320 Richardson Road, Federalsburg, MD determined (Specify) School Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 20, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 32. Registrat's Signature State

ORIGINAL

OCME

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Scott Troutman 10:50 PM July 13 2007 /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b, City, Town, or Location of Death Examiner Anne Arundel Ginger Cove Health Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, March 7, Annapolis 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** ^{Year)} 1930 XX M 2□ F Missouri Director 487-30-2094 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 □Yes XXNo Directo Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21401 United States 3211 River Crescent Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★ ☑ Yes 2 ☐ No 1952-1 4es, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 🛣 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 5+ Management Consulting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilma Gretchen Freiling Bervl Alfred Troutman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Maryland 21401 Ellen S. Troutman / Wife 3211 River Crescent Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 7/17/2007 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mich 6 147 Duke of Gloucester ST. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final les **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Severe and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria with Bleest fromtum Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 21 certificate 1 ☐ Yes 2 ☐ No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 20 + Ver Harry ANAPULS MAZIYOI GBR

Registrar

State

		•	For State Registrar	State of Maryland /	•	rtment of H tificate of L			jiene 1eg. No∠ Û U	7 2 1845
	中等		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physicia		Agnes Bernadett	a Tallev				July		007 11:56P M
	/Medic Examin		4a. Facility Name (If not institution, give st		1	4b. City, Town, or	Location of Dea		4c. County of	Death
		30	Gladys Spellman	•		(Chever1v	<i>r</i>	Prin	ce George's
	- Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hr		9	Birthplace (State or Foreign Country)
	Director		217-60-7304	^{M 2} ∑ F 56	Yrs.	Months Days	Flours Will	May 21		Wash. DC
41	D.		Usual Residence of Decedent							404 Inside City Limite
	rylar show		10a. State 10b. County	10c. City, To	wn or Loc	cation				10d. Inside City Limits 1 Yes 2 □ No
	e Ma Sa-f s	cto	Maryland Montgo	mery			Silver S			**
	death with the Maryland ms 23s or 28s-f show rmust be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	23a		15145 Deer Val	ley Terrace			20906			d States
	r deg	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (.n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Black,	American Indian, White, etc.
9	or It		1 XNever Married 2 Married	1 ∐ Yes 2 MNo If Yes, Give	1	☐ Yes 2♥ No	Specify:		Specify:	African
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and	ntal h	Be							achel Rob	incon
Ž	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, the Medical Exercities maste and ities and aumatic event, the Medical Exercities in the fired at a fired than the fired at a fired than the fired at a fired than a fired than the fired at a fired than the fired at a fired than the fired at a fired than the fired than t	2	Archie Talley 19a. Informant's Name/Relationship (Typ.	a Print) 10	h Mailin	a Address (Street	and Number or F	Rural Route Numbe		
Maryland 21215-0036	12 si h an 7 is r traur		Audrey B. Talley/			•				ng, MD 20906
	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition	20b. Place	of Dispos	sition (Name of		Date	20c. Location - Ci	
altimore,	Pages nent of I int: If Its iry or o		1 Burial 2 ☐ Cremation 3 ☐ Re	moval from State	•	natory or other plac		7/2007	т 1	MD
#	t. Pag rtment rtant: I		4 Donation 5 Other (Specify)			emorial l			Landove Funeral F	
Ba	permit. Departmimports Imports any inju		21. Signature of Funeral Service License		22		enning F		Wash., DO	
, i	40244		23a. Part1. Figter the disease, or complic	etions that sourced the death D	not ente					Approximate
			shock, pil heart failure. List only on	e cause on each line.						Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequence Aterior of C	e of):	, B	/		Allas	Coperal
		_	Sequentially list conditions, b.	Due to (or as a consequence	201	The Co.	WIICK	www !	D'acup	gears
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Bus to (or us a consequence	0 01/2					
_	and and	xan	that initiated events c. resulting in death) Last	Due to (or as a consequence	e ol);					
8760,	Attending Physician: The law requires that the death certificate be executed in death. •ctor: After this certificete hes been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	<u>ea</u>								
87	phys the	dlcal	4							
ox 6	leath certific attending p	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			-		23d. Date	of delivery
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o.	the d	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown	3	Carlor (apochy)				
Δ.	that the de led by the a detached f		Part II. Other significant conditions con	tributing to death but not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
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<u>S</u>	death death ctor: /	cat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,	larm etc			28f Location (5	Street and Number	or Rural Route Number,
\leq	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	raini, sti	eet, factory, office		City or Tox		
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he cumpletely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	ician: To the best of my knowled	lge, death	a occurred at the tir	ne, date and nia	ce, and due to the	cause(s) and mann	ner as stated.
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	To the within 2 To the cumpled	Me	29b. Signature and title of certifier	0		29c. Licens			29d. Date signed (
	D 1 2 - 3		10 M. M. C.	21/20G		10/	850		Sucy 17	- 2007
n	(2)		30. Name and address of person who co	mpleted cause of death (Item 33)	a) (Type	Print)				
16			(D) A ()=1/	ADE NO (ADT	Z (Type,	0.00.70	Chen C	201 Husa	this	- 2007 eMD20781
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	Regist		1111 2 0 2007	ham A. Do	M					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JÜĽŸ 17^{Day} 2007 8:35 PM ROSIE L. TERRANCE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES CIVISTA MEDICAL CENTER LAPLATA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 4 / 24 / 4] 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2/□F 66 Director 426-80-6449 MISSISSIPPI Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at 1√Yes 2□No Completed by Funeral Director LA ORLEANS NEW ORLEANS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 2538 ST. U.S.A. 14. Race - American Indian, PHILLIP STREET 70119 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HAIRSTYLIST COSMETOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta important; If item 27 is marked any injury or other traumatic ev 2 HUSTACE MARSHALL JIMMIE SUTTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA TAYLOR/DAUGHTER 11155 LORD BALTIMORE DR. SWAN POINT, MD 20645 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1♥ Burial 2 □ Cremation 3 ▼Removal from State 4 □ Donation 5 □ Other (*Specify*) ST. AUGUSTINE CEM. 7/26/07 NEW ROADS, LA 22. Name and Address of Facility STRICKLAND FUNERAL SERVICE 21. Signature of Funeral Service Licensee 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 23a. Part1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is ponly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JEPSIS **Physician** days /Medical Due to (or as a consequence of): cancer with metastatic spread Examiner Ovarian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): burial Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12, months?
1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has I page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Division or Vital Records, P.O. Box 68760, or Attending Physician: after death. completely filled in by To the Hospital within 24 hours a To the Funeral L Hospital Medical Registrar

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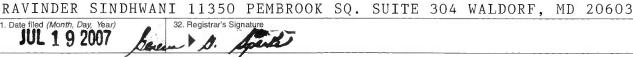
requires that the death certificate be executed

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

filed (Month, Day, Year) JUL 1 9 2007



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D- 61614

29d. Date signed (Month, Day, Year)

07-05436 Robert A. Veltri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month July 16, 2007 Year 0242 hrs **Medical Examiner** Robert Allen Veltri 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Germantown 13421 Clopper Road 9. Birthplace (State or 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland
Country) Months Days Hours Dec. 6, 1973 Director 220-86-1 33 1 X M Yrs 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 x No Annapolis 23a or 28a-f show notified at once. Anne Arundel Maryland with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21409 417 Peach Court 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital Status White etc. a If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death v Armed Forces? Never Married 2 Married 2 1 X Yes Specify: White Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after neut of Health and Mental Hygiene. 4 X Divorced f Yes, Give Year 1994-2000 other tranmatic event, the Medical Examiner is marked other than "natural", þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private Industry Law Enforcement 2 Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Debra Peirce John Francis Veltri Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13434 Rising Sun Lane, Germantown, MD 20874 John Francis Veltri/Father If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) Burial 2 XX Cremation 3 Removal from State July 20 Metropolitan Crematory 2007 Donation 5 Other Specify Alexandria, Virginia 'n 21. Sign wire of Funeral Service Licens 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. T_AT Silver Spring MD 20901 Blvd, mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I. Enter the disease, or co Physician Between Onset and failure. List only one cause Death Medical Contact Gunshot Wound of Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pur Physician/Medical 5 per fh g870 8-23-07 vt X AMENDED physician a UNPENDED The law requires that the death certificate be Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE 3 Ectopic pregnancy Year 23b. Was decedent pregnant in the Day Live birth Fetal death signed by the attending be detached for use as I past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ Completed Records, 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autonsy performed? death? No Yes 2 [Yes 2 certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: Residence 6 🗸 Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject shot self Certification: FOUND: Yes 2 V No Natural Pending hours after death. To the Funeral Director: completely filled in by the Jul 16, 2007 0230 hrs Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) 13421 Clopper Road, Germantown, MD determined (Specify) Field Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 241 Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 16, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner

State

Registra

31. Date filed (Month, Day Year

2007

OCME

		-	For State of Maryland / Depa 1 - State Registrar Cer	rtificate of Death		ene g. No.		
	Physicia	1. Decedent's Name (First, Middle, Last) Physician Kathleen C. Vincent			2. Date of Death Month July	16, 2007 11:20a M		
1	/Medio Examin	200	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Pasadena	7 1	4c. County of Death Anne Arundel		
	Funeral Director		253 Magothy Bridge Road 5. Social Security Number 017-14-6157 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Aug. 12	9. Birthplace (State or Foreign		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 21s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1		
larylan			10e. Street and Number 253 Magothy Bridge Road	10f. Zip Code 21122	100	g. Citizen of What Country? USA		
			1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		ib. Kind of Business/Industry Home		
	ld be filed ental Hygi ked other ic event, t		17. Father's Name (First, Middle, Last) Lawrence Joyce 18. Mother's Name (First, Middle, Maid Sarah Finnegar			*		
	and 2 should lealth and Men m 27 Is marken her traumatic		19a. Informant's Name/Relationship (Type. Print) Maureen Toops/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8301 Fairwood Drive Pasadena, MD 21122					
Baltimore,	Pages 1 an nent of Heal ant: If Item 2 ary or other		4 Donation 5 Other (Specify) Arlingtor	n National Cem. Au	2007	Oc. Location - City or Town, State Arlington, VA		
Pall	permit. Page Department of Important: If any injury or once.			2. Name and Address of Facility arranco & Sons, P. 95 Gov. Ritchie Hv		rna Park Funeral Home rna Park, MD 21146		
ecords, P.O. Box 68760, aw requires that the death certificate be executed great	Physician /Medical Examiner sthe parisite private is the parisite parisite private in the parisite private in the parisite parisite private in the parisite private pr	Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ 1 □ Yes			23d. Date of delivery Month Day Year		
	quires that n signed by ald be deta					cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 Unknown		
	: The law rec cate has beel page 2 shou		,			y prior to completion of cause of death? No 1 □ Yes 3 □ No		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.		25. Was case referred to medical examiner? 1 Yes 2 No	28d. Describe hor	dence 6 □Other (Specify) now injury occurred			
Ž Ž	oital or At urs after d ral Direct		4 Homicide determined determined building, etc. (Specify)					
	the Hosp nin 24 hou the Fune npletely fi		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month. Day, Year)					
)	2 N 2 00		29b. Signature and title of certifier M	D 51591	0 3	July 18, 2007		
	65K		30. Name and address of person who completed cause of death frem 23a) (Type, K-Awbalavanav 7845 (Dark wood Roc	ad G	Len Burnie MD21de		
	St: Regist	ate rar	31. Date filed (Month, Day, Year) 32. Register's Signature 19 2007	South !				

DHMH 17 Rev 1/2001

Maryland 2121

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18 713AM WALTER TOMLIN VANAMAN Juli 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Doctor's Community Hospital Prince George's Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Director 517**-**12**-**4758 11-20-1915 91 New Jersey Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 ☐ No Director Maryland | Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? an "natural", or items 23a or Medical Examiner must be r 4803 Oglethorpe Street 20737 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 X Married WWII 1 ☐ Yes 2 X No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other traumatic event, the Construction Engineer Construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Pages 1 and 2 should be f ment of Health and Mental I ant: If item 27 is marked o Emmett A. Vanaman Bertha Tomlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred E. Vanaman Wife 4803 Oglethorpe Street, Riverdale, Maryland 20737 timore. : If item ? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department (Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/19/2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. nichelle L' M01491 Hyattsville, MD 20781 /her le 23. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive **Physician** Cardiova Lucian disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of) physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed?
Yes 2 Vo page 2 1∐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation nin 24 hours after death the Funeral Director: 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) و مرابع ا MSD 12863 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVENLY MD LANDOVER READ MOLAVI 4005 1.1. MASS AN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTATE of Many 12nd & Poeph Himen 687 Realth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 July 19, William R. Warfield 11:45 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cambridge Dorchester Chesapeake Woods Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June, 26 Year 1924 Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 12M 2□F Months Hours 83 220.12.0580 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Cambridge 1 ☐ Yes 2 ☐ No Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 **USA** 5464 Ragged Point Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ NO Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wire Cloth 6 Wire Cloth Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laura E. Tyler Russell E. Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5464 Ragged Point Rd., Cambridge, MD 21613 Rosemary A. Warfield/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State Spedden-Seward Cemetery 7.22.2007 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 nature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stat +a MPACS Due to (or as a consequence of) Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 16 24a. Was an Pin Accident Spi ou Yes 2016 25. Was lase referred to medical exam...er? 1 Yes 2 No Other: 4 sing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Ceath
Matural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

/Medical Examiner use as the burial-transit or Attending Physician: The law requires that the deeth certificate be executed physician and Division of Vital Records, P.O. Box 68760, signed by the a Id be detached for page 2 s certificate this : After this funeral o death. Director: To the Hospital within 24 hours e To the Funeral C completely filled i pelii

Physician

Examiner

Directo

Funerai

δ

Completed

Be

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Examine

Physician/Medical

δ

Certification; To Be Completed

Medicai

29b. Signature and title of certifier

60.3

31. Date filed (March B)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.0

Registrar's Signature

NARR

2007

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified a once.

Physician

Baltimore, Maryland 21215-0036

/Medical

10 State

Registrar

DHMH 17 Rev 1/2001

Transfer of

29c. License number

29d, Date signed (Month, Day, Year)

7-20-07

Certificate of Death

100

E.

32. Registrar's Signature

23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salis bury

3. Time of Death

2349

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

9. Birthplace (State or Foreign

Maryland

White

Year

07

State Registrar Anthony

31. Date filed (Month, Day, Year)

Carroll

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician July 22. 2007 4:55 РМ Franklin Wertman, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Williamsport Homewood Retirement Center 8. Date of Birth (Month, Day, Yea Sept. 12, 5. Social Security Number Age (In vrs. last birthday): Birthplace (State or Foreign Country) **Funeral** Year) Months Days 1**X**M 2□F Yrs. 1930 Pennsylvania 203-22-9375 76 Director Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n items 23a 21795 USA 16505 Virginia Avenue C-961 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. The marked other than "natural", or items 23s and it if item 27 is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electronic Company 12 4 Computer Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Wertman Sr. Ruth. Emma Watts ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16505 Virginia Ave. C-961 Williamsport, MD Jimmylene Wertman (wife) 21795 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 7-23-07 Smithsburg, Maryland 21. Signature of Funeral Service Osborne Funeral Home P.A. 425 South Conococheague St. Williamsport, Maryland 21795 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Imm diate Cause (Final **Physician** MONTE disease or conditior resulting in death) /Medical (or as a consequence of): Examiner 16DLASTINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 DUnknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has page 2 autopsy 2 1 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Land Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes Director 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation in the cause of examination and or investigation and or 29a. Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. 29b. Signat 29c. I feense number 29d. Date signed (Mgnth, Day, Year)

シャタナ) State Registrar 30 Name

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1ETZNGL

07-05380

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

evin L. Warren	1-For State Of Maryland / Department of n		Reg. No.	J) 2:35		
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2 Date	of Death	3. Time of Death		
Aedical Examiner		July July City, Town, or Location of Death	Day Year 14, 2007	0310 hrs		
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Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		e of Birth (MM/DD/YYYY) 9. Bi Forei			
Director	212-13-0036 1X M 2 F 29 Yrs.	Months Days Hours Min. 03		Manyland		
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
<u> </u>	Virginia Chesterfield	Richmond		1 Yes 2 No		
he Maryland t or 28a-f show ified at once. Director	Too. Stroct and Hambon	of. Zip Code 23237	10g. Citizen of What Cou United			
	5235 Plum Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (Specify Ye		rican Indian, Black,		
r death with or items 23 must be no	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	specify Cuban, Mexican, Puerto Ricán, e	tc.) White, etc.			
s after d	3 Widowed 4 Divorced If Yes, Give Year 1 Ye	s 2 No specify:	Specify.	Black		
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Jsual Occupation (Give kind of work done of working life. DO NOT use retired)	e 16b. Kind of Business	/industry		
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan Completed	12th	Cook/Carpentry	Pr	ivate		
5-00 led will led will led will let will let let M		18 Mother's Name (First, N	diddle, Maiden Surname)			
21215-0036 Mortal Hygiene. marked other than e event, the Medica	Thomas C. Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ai	Pat ddress (Street and Number or Rural Ro	cricia L. Powe ute Number, City or Town, Star	11 te, Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical I To Be Complet	Patricia Warren/Mother 6802	Greig St., #101, S	Seat Pleasant,	MD 20743		
re, fresh fr	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other	n (Name of cemetery, Date place) Park	20c. Location - City of	or Town, State		
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	4 Donation 5 Other Specify: Maryland N	ational Mem. 7/21/2				
Balt permit. Depart Import injury	21. Signature of Funeral Service Licensee 22. Nan	e and Address of Facility Stews 4001 Benning Ro	ert Funeral Ho			
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	node of dying, such as cardiac or respira	itory arrest, shock, or heart	Approximate Interval Between Onset and		
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wounds of Torso and Arm			Death		
A CAGITITION	or condition resulting in death) Due to (or as a consequence of):					
ğ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
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876 tiffcate ng phy as the l	F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal	death 3 Ectopic pregnancy	Month	Day Year		
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D. B. t the de by the ached f	Part II. Other significant conditions contributing to death but not resulting in the unc	Citying dadoo giron iiri airi	se. Did tobacco use contribute			
P.C.	i'		Yes 2 No 3 P			
Records, The law requires ficate has been significate has been significate has been significate has been significant of the second seco			autopsy prior t	autopsy findings available to completion of cause of		
Reco		15	performed? death Yes 2 No 1			
cian: Certifi	25. Was case referred to medical	26. Place of Death (Check only one		ner: Scene		
f Vi Physi er this eral dir	1 Ves 2 No Impatient 2 ENOutpatient 27 Manner of Death 28a Date of Injury 28b. Time of Injury	iry 28c. Injury at Work? 28d. D	escribe how injury occurred	nor. decite		
Division o spiral or Attending rours after death erral Director: After filled in by the fune	1 Natural 5 Pending Jul ^(Nonth, Day Year) 0257 hrs	1 Yes 2 ✓ No Subje	ect shot			
ivisior or Attend after death Director:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	or	ocation (Street and Number or Town, State)			
Di Spital hours e / filled	4 W Homicide determined (Specify) Sidewalk Westbound Central Avenue, Capitol Heights, Md. 29a. Certifier (Check of ID) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Centifying Physician: To the best of my knowledge, death occurre one) Medical Examiner: On the basis of examination and/or investigation	a at the time, date and place, and due to	me, date and place, and due to	the cause(s)		
To To con	and manner stated. 29b Signature and title of certifier	29c. License number	29d. Date signed (/	Month, Day, Year)		
7	((anderheur)	O.C.M.E.	July 14, 2007			
R (4)	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn 3	Street, Baltimore, MD 21201				
State 31. Date filed (Month, Day Year) Registrar 111 2 0 2007 Registrar						
Registra	11 11 2 0 2007 Bear S. Speck					

DHMH 17 Rev 1/2001 OCME 2006

Evelyn Woods

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05246 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 8, 2007 Year 2020 hrs WOODS **Medical Examiner** EVELYN 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Bowie 14403 Dunwod Valley Drive If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Min. Director MAY 10 1957 CountryASHINGTON 577-78-7862 1 M 2 7 F 50 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location any 10a State 10b. County 1 X Yes 2 No s 23a or 28a-f show e notified at once. or 28a-f show PRINCE GEORGE'S BOWIE MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code U.S.A. 20721 14403 DUNWOOD VALLEY DRIVE ō 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or Noitems must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? permit. Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examiner must be 1 Never Married 2 X Married Yes BLACK Yes 2 X No specify: If Yes, Give Year Widowed Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 OFFICE MANAGER GOVERNMENT 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DAISY HARRIS Be CALVIN TOWNSEND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 14403 DUNWOOD VALLEY DRIVE BOWIE, MARYLAND 20721 THEODORE WOODS JR./HUSBAND 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) Removal from State ^Z*Burial 2 Cremation 7/17/2007 LANDOVER, MARYLAND HARMONY CEMETERY Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. Jenkins Funeral Home ROAD LANDOVER, MARYLAND 7474 LANDOVER 20785 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line. Medical Death a Gunshots (2) to the Head Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Friter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? 2 Pregnant at time of death Other (Specify) 5 Yes 2 No 9 ✓ Unknown certificate has been signed by the att ector, page 2 should be detached for q Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 V No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No Yes 2 26 Place of Death (Check only one) e Hospital or Attending Physician: 124 hours after death. 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 FR/Outpatient 3 DOA this ۵ 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury Jul 8, 2007 After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot 2000 hrs Natura Yes 2 V No Pending Funeral Director: tely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 14403 Dunwood Valley Drive, Bowie, Md. (Specify) Single Family determined 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 9, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

OCME

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year 10:15P M July 2007 Patricia Ann Williams-Anderson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Clinton If Under 24 Hrs. Prince George's Southern Maryland Hospital If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 TF Mar. 26, 1949 577-68-3265 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 17 Yes 2 □ No Suitland Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3049 Sunset Lane 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify: Specify: Black. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Williams Ernestine Lake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20721 Gregory Taylor/Son 11031 Spyglass Hill Ct., Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2007 4 ☐ Donation 5 ☐ Other (Specify) Washington National Suitland, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Wash., DC 20019 4001 Benning Rd., NE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C-use (Final disease or condition resulting in death) AWTE MYCCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any the distribution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES 1 | Yes 2 | No 3 | Probably 4 | Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natures" any injury or other traumatic executions.

/Medical

10a State

Director

Funeral

Completed by

Be

P

attending physician and for use as the burial-tran signed by the a d be detached for peen has

The law requires that the death certificate be executed

To the Hospital or Attending

Division or Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner page 2 certificate Be Certification: To this within 24 hours after death.

To the Funeral Director; After the

9 Unknown

25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one,

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

5 ☐ Pending investigation

27. Manner of Death

2 ☐ Accident

(Check only one)

D40324

JULY 13, 2007

20735

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

2 □ No

autopsy performed

2 No

28d. Describe how injury occurred

1☐ Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD, CLINTON, MARYLAND

TERRY JODRIE, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Medical

Gener D. Specks

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Cemida Yousef July 16, 2007 11:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 336 Hammonton Place Silver Spring Montgomery If Under 1 Year | If Under 24 Hr 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 ⋤ F Director 219-34-9702 80 Aug. 26, 1926 Colombia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 336 Hammonton Place 20904 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Colombian White Baltimore, Maryland 21215-0036 "natural", or 1 XYes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than ", the Mr Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugenio Bonet Solano Eudocia Trujillo de Bonet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 336 Hammonton Place, Silver Spring, MD 20904 Jamil H. Yousef/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc cheen 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or comulications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Hypertension 30 Years Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Examin physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown Alzheimer's Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 😾 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) Adolph W. Johnson, M.D. 12520 Prosperity Drive, #150, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 18

07-05874 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Corloyd Anderson 1- For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Year 0920 hrs Medical Examiner August 1, 2007 CORLOYD **ANDERSON** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1111 N. Monroe Street **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) g. Birthplace (State or **Funeral** Months Days Hours Min Director 49 05/13/1958 Country) MD 213-36-1731 1 **X**M 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 1111 N. MONROE STREET 21217 USA the ? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2 Married Yes 2 X No 0 f Yes, Give Yea Specify: BLACK Divorced Yes 2 X No specify à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I other than " the Medical J than Department of Health and Mental Hygiene. Important: If Item 27 is marked "" 21215-0036 be filed within CARPET LAYER **V&W CARPET SALES** 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ WILLIAM A. ANDERSON

19a. Informant's Name/Relationship (Type, Print) BURNETT GLORIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, GLORIA ANDERSON/MOTHER 21217 1111 N. MONROE ST. MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 8-7-07 Memorial rark Donation 5 Other Specify: nature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701-31 LAURENS ST. BALTIMORE, MD Approximate Interval 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Narcotic intoxication (mornhine) Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical g physician a X UNPENDED AMENDED #23a,PII,27,28a-f, perME,g870, 8/13/07 TT The law requires that the death certificate be Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death as past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive atherosclerotic cardiovascular disease Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available End stage renal disease prior to completion of cause of autopsy has performed? death? certificate l ✓ Yes 2 No ✓ Yes Νo Cachexia To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natura 1 Yes 2 X No e Funeral Director: / Pending Fnd 8/1/2007 Fnd 9:00 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be 111 N. Monroe St. Baltimore, MD found in residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 1, 2007 O.C.M.E. una 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD

State Registrar

31. Date filed (Month, Day, Year)

32. Redistrar's Signature ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician ELANOR ELIZABETH ARRIGO AUGUST 1, 2007 11:00A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FRANKLIN WOODS NURSING FACILITY ROSEDALE BALTIMORE 8. Date of Birth (Month, Day, Year) 9-19-197 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days 1 □ M 2 X F MARYLAND 212-09-7392 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State FINKSBURG 1 ☐ Yes 2 No MD CARROLL Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21048 2809 ARMACOST AVENUE Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: WHITE þ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be (SPURRIER) SCHUETTE ANNA FREDERICK ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2809 ARMACOST AVENUE 21048 FINKSBURG, MD PATRICIA BAUMGARDNER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State GARDENS OF FAITH C 8-6-2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown Part IL. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🕍 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death

12 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 Is marked other the any Injury or other traumment. Physician /Medical Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. After t

Examiner burial-tran the ed by the a certificate this 24 hours after death. within 24

/Medical

Examiner

Funeral

Director

show

28a-f the

notified

ms 23a or must be n with

'natural", or Items dical Exa⊞lner mu

Maryland

death

State

Registrar

Medical

Muneses

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

MM

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

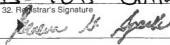
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 127

ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad

Onkwood Road Glen Bouring MD 21061 2845 MD Juge

31. Date filed (Month, Day, 2007 AUG 0



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner osedale vaire If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9-8-1917 9. Birthplace (State or Foreign **Funeral** 89 Months 1**X** M 2□ F Hours MARYLAND 220-07-1471 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ny Injury or other traumatic event, the Medical Examiner must be notified at ROSEDALE MD BALTIMORE 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7917 UNDERHILL ROAD 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1941-53 "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) UNITED STATES Elementary/Secondary (0-12) 1 2 marked other than College (1-4or 5+) POSTAL CARRIER POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F Be adino, DOMINICK AOUINO MARY (MESSINA) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POSEDALE MD 21237 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is JOAN P. AQUINO/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) METRO CREMATORY 8-3-2007 CATONSVILLE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service License 1211 CHESACO AVE 21237 ROSEDALE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pronchiectasi if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 ☐Unknown culli Anemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes ertension 2 🗌 No Yes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 No Hospital: Other: 1 Inpatient 1 🗌 Yes Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Q,

State Registrar (Check only one)

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Square Drive Baltimore MD. 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

obert Ambrose		State of Maryland / Department of Health and Mental For State Certificate of Death		. No.	77 of he			
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	to up by	3. Time of Death 2125 hrs			
Medical Examir		Robert Lee Ambrose 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	July 29, 200	4c. County of Dea				
	н	501 Union Avenue Harford Memorial Hospital Havre De Grace		Harford				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	_	(MM/DD/YYYY) 9. B				
Director	l	212-23-3060 1x M 2 F 19 Yrs. Months Days Hours M	July 8	, 1988	ountry)Maryland			
B DY	[Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
≩		Maryland Cecil Rising Sun			1 Yes 2 X No			
Maryland 28a-f show d at once	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		18 Wilson Road 21911	Į	JSA	-			
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (12. Never Married 2 Married Armed Forces? 14. Was Decedent of Hispanic Origin? (15. Never Married 2 Married Forces?		14. Race - Ame White, etc.	erican Indian, Black,			
er deat		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Wh	ite			
hours afte 'natural''.	9	Lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business				
72 hor	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) MONTON	etired)					
5-0036 lted within 72 Hygiene. I other than the Medical	E C	12 Mover	/First Middle M	Moving Co	mpany 			
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2121 ould be fill Mental H marked ic event,	TO B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			ite, Zip Code)			
e, MD 1 and 2 sho Health and item 27 is		Robert William Ambrose/Father 18 Wilson Road, Risi		21911				
ore, s l and of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State			
imore Pages 1 ment of H tant: If i or other		4 Donation 5 Other Specify: Highview Mem. Gardens 0		Fallston.				
Baltimore, permit Pages Lan Department of Hea Important: If iter				unearl Ho				
Physician	-	23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial	c or respiratory arre	Idon , Mary st, shock, or heart	Approximate Interval			
Medical		failure. List only one cause on each line. Between Onset and Death Death						
Examiner		or condition resulting in death) Due to (or as a consequence of):	Selection					
	<u>.</u>	Sequentially list conditions, b. Due to (or as a consequence of):						
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated C		111111111111111111111111111111111111111				
led nsit	Exa	events resulting in death) Last Due to (or as a consequence of):						
execu an and	Medical	UNPENDED X AMENDED #4a, perME, g870, 8/3/07 TT						
'60, ate be	Med	#4a, pervir., go/U, O/3/U/ 11 IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv				
23b. Was decedent pregnant in the past 12 months?				Month Day Year				
30X death death a for u	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)						
O. E at the d by the stacked		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?			
S, P.	ed by		_		robably 4 Unknown			
ords w requisible been shoul	plet		24a. Was a autops perfor	sy prior t	autopsy findings available o completion of cause of			
Rec The la	Be Completed		1 ✓ Yes 2					
Let (1 of Vital Rec ing Physician: The After this certificate Uneral director, page		25. Was case referred to medical examiner?		Residence 6 Ott	her:			
FCI Physical din	T _o	1 V Yes 2 No 28a Date of Injury 28c Injury 28c Injury at Work?		ow injury occurred	ilei .			
On C anding th.	tion	1 Natural 5 Pending FOUND: 1 Yes 2 ✓ No	Ejected pass	senger of motor	boat			
Division tal or Attendi rs after death.	fica	2 V Accident Investigation 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, S		Rural Route Number, City			
Divinal of ours at filled in	Certification:	4 Homicide determined (Specify) Bay	Garrett Island	Chesapeake Bay,				
Division of Vital Records, To the Hospital or Attending Physician: The law requirently hours after death. To the Funeral Director: After this certificate has been seempletely filled in by the funeral director, page 2 should	cal (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
To the within To the comp	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (/				
	_	O.C.M.E.		July 30, 2007				
		30. Name and address of person who completed cause of death (Item 23a)						
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature								
Regis	=	ALIG 0 3 2007 Regulation						
DHMH 17 Rev 1/2	UU1	ORIGINAL						

State of Maryland / Department of Health and Mental Hygiene... Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** errence James /Medical Fecility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Center Square Hose da le

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. timore Franklin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours 1 M 2 F Director None Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Baltimore 1 Yes 2 □ No Completed by Funeral Director MID 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23s or 21766 ISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 211 No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4or 5+) is marked other than NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 2 errence James Bell Shawnda Johnson permit. Pages 1 and 2 should Department of Health and Milmportant: If Item 27 is martany injury or other traumattones. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) woval from State

20b. Place of Disposition (Name of Semestery, crematory or other place) LaShunda 20a. Method of Disposition Baitimore, mo 21006 Baltimore, Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1 Memorial 08.04.3607 Baltimore, mo 22. Name and Address of Facility Vorynn C. Greene uneral Service Holly Hill memorial ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vaushin C. Under \$728 Liberty Road Randow

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Road Randaulstown MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** rematuriti resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe I 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 (Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral I 16d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and address of person who completed caus Source Drive Angelika 31. Date filed (Month, Day, Year) Registrar's Signature State 2007 AUG 0 3

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Beard 8:251 M 07 DI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice TICHVIST Baltimore DWSDV If Under 1 Security Number 7. Age (In yrs. last birthday) ear I If Under 24 Hrs. 8. Date of Birth (Month, Day) **Funeral** Months Days 081.24.048 1 □ M 2 ▼ F 83 Yrs. 08/16 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 XYes 2 □ No MD Baltimore Completed by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21218 Street ttomestead Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 XNo Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Black 3 Widowed 4 □ Divorced Year or Dates: "natural" er than "natur, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Domestic 12th grade is marked other 17. Father Mame (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucy Ethel P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street Baltimore MD item 27 i ttomestead Konnie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If Ite
any Injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Owing Mills, MD Garrison Forest VA 08 09/07 4 Donation 5 Dother (Specify) Vaughn C. Greene Funcial Sruce 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mo1363 4905 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL ACUTS Physician DAUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has birector, page 2 s autopsy 2 2 Tyc To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Sther (Specify) 1 Yes 2 No HOSPICE Medical Certification: To this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i Director: After t d in by the funera 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title D 64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NORTH CHAPLES ST, STE 216, TOWSON, MD 21204 DANIEUE DOBERMAN, MD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

07-05807 Vance Rurnette

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Vai	ice burriette		State of Maryland / Department of Health and Mental Hyter State Certificate of Death	glerie Reg. l	No	•••
	Physici	an/		2. Date of Death	3	. Time of Death
	edical Exami ્ર	ner		July 29, 200		0837 hrs
	1		4a. Facility Name (if not institution, give street and number) Good Samaritan 4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Birth	place (State or
н	Director		215. 68. 4633 17M 2 F 49 Yrs. Months Days Hours Min.	09/16/	1957 Foreign	try) MD
			Usual Residence of Decedent 10a. State 10b. County , 10c. City, Town or Location		1	0d. Inside City Limits
	d how ar	L	MD N/A Baltimore			Yes 2 No
	daryland 28a-f show 1 at ouce.	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Countr	y?
	215-0036 be filed within 72 hours after death with the Maryland nital Hygiene rked ofter than "naturial", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		TIO Beaumont Avenue 21212		USA	{
	ath with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R		14. Race - America White, etc.	in Indian, Black,
7	her de: ", or i		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B	ack
3	2 hours after "natural". Examiner	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire		b. Kind of Business/Ind	lustry
	36 thin 72 h thau "u	plete	Elementary/Secondary (0-12) 10 Harade College (1-4 or 5+) N/A Meat Cutter	7	Whole	Foods
	5-003 lled withi Hygiene I other th	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name (100		, ,
	21215-0036 uld be filed within 72 hours a Mental Hygiene marked other than "natura c event, the Medical Examin	Be	Vance Burnelle, Sr. Many			
	D 2	٢	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Mary Burnette / Mother 710 Beaumont			
	re, MD 2 s 1 and 2 shou of Health and N If item 27 is n		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		Oc. Location - City or T	
	는 8 년 프 월			04/07	Windsor	Mill, MD
	Baltimo permit, Page Department Important: injury or oth	70	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	who C.	Greene Fu	neral Smos
	Physician	2 1	23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			2/2/2 Approximate Interval
	/Medical	0.0	failure. List only one cause on each line. Immediate Cause (Final disease a. Heroin and methadone intoxication			Between Onset and Death
1	Examiner		or condition resulting in death) Due to (or as a consequence of):			
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
6		Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated experts resulting in death). Last purpose resulting in death). Last purpose resulting in death). Last purpose resulting in death). Last purpose resulting in death). Last purpose resulting in death of the control			
	ecuted and - transit		events resulting in death) Last Due to (or as a consequence of): d.			
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	3760, ficate b g physic s the bur	λ/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	icv	23d. Date of delivery Month Da	y Year
	Box 68760, e death certificate be exthe attending physician of for use as the burial	iciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		Month Da	y rear
	. Boy he death y the att	hys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did toba	cco use contribute to th	e cause of death?
	cords, P.O. Base aw requires that the denaste been signed by the substantial bedeathed for substantial and sub	by	Part II. Other significant conditions — contributing to death but not resulting in the uncertying cause given in Part I.		2 No 3 Proba	
	'ds, require been si	Completed		24a. Was an		psy findings available
7	tal Records cian: The law requi certificate has been ector, page 2 should	Jumo		autopsy performe	d? death?	mpletion of cause of
5	an: The	Be Co	25. Was case referred to medical 26.Place of Death (Check or		10 10	
井	of Vita ing Physici After this or uneral direc	To B	TV res z No		sidence 6 Other:	
	Division of Vital Records, tal or Attending Physician: The law requir its after death. al Director: After this certificate has been s led in by the funeral director, page 2 should I	on:	1 Natural 5 Pending (Month, Day, Year)	28d. Describe hov	vinjury occurred	
=	ivisior or Attend after death Director:	icati	2 Accident Investigation FIRC 1/29/2001 FIRC 0:20 am 1	unk 28f. Location (Stre	et and Number or Rura	I Route Number, City
Nanne	Div oital or ors after rral Di	Certification:	Suicide 6 X Could not be	or Town, State 710 Beaumo	_{e)} nt Ave. Balti	more. MD
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control of the control of the time, date and place, and control of the	due to the cause(s) and manner as stated	l.
	To th within To th	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated. 29b. Signature and title of certifier 29c. License number		9d. Date signed (Mont	
			O.C.M.E.		July 30, 2007	
			30. Name and address of person who completed cause of death (Item 23a)			
			Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
	Si Regis	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene per dr., g870,08/03/07dbb Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deat07/27/2007 3. Time of Death **Physician** 12:45 AM Marie Bisesi र्राप्टीय /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Howard Mont Clare Assisted Living 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday, **Funeral** Days Hours 1□M 2√F 215**-**14-4210 Director 86 1921 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Cheddington Road U.S.A.

14. Race - American Indian 21090 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ∏ No Specify: Specify: white ò 3 ∑Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Book Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Sternat Louisa Weiber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Mather/Daughter 209 Cheddington Road Linthicum, MD 21090 | 205 Greatington Road Efficient, In 21030 | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or Town, State | 20c. Location - City or T 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Opnation 5 ☐ Other (Specify) 21. Si mature of Funeral Se 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final Alsheimen dementia

Duer (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Due to (or as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform this certificate 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No ည 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

al or Attendi s after death. Il Director: A filled in by the within 24 hours a 2

State Registrar

Medical

29b. Signature and title of certifier

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DD55437

July 27, 2007

on who completed cause of death (Item 23a) (Type, Print)

Elizabeth Kower

31. Date filed (Month, Day, Year) AUG 0 3 2007 10711 Birmingham Way Woodstock, MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		State Registrar Decedent's Name (First, Middle, Lasi)		Cel	rtificate o	Death		2. Date of Deat		157	3. Time of Death
hysici: /Medic	_	Elizabeth	l l	W.	Ba	ailey			July 3.	1, 200	7 Year	4:30 P
Examin		4a. Facility Name (If not institution, give				4b. City, Town				4c. Cour	nty of Death	
		Solomons Nursin 5. Social Security Number 6. Se	~	er 7. Age (In yrs.	last hirthday)	If Under 1 Yes	colomor		8. Date of Birth		Calv	
uneral rector			_̂м 2\(\) к	88	Yrs.	Months Day		Min.	Month, Day, Dec 16,	Year)	Ohi	nplace (State or Fore untry) O
at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limi
a-f sl tiffed	ctor	Maryland Charles			Waldor	f						1 □ Yes 2 💢 🧷
a or 28 be no	Funeral Director	10e. Street and Number 3204 Bethesda	Drive			10f. Zip Code	0601		1	0g. Citizen o	of What Cou ted S1	
ns 23 must	eral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.\			rigin? (Spe	ecify Yes or No-	14. R	ace - Amer	ican Indian,
marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Given Year or D	XX No							lack, White	
atural cal Ex	ted t	15. Decedent's Edu	ucation	dies.	16a. Decedent's Usual Occupation 16b. Kind of Business/Indust						ndustry School	
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her th		17. Father's Name (First, Middle, Last)			Belloc	DI Becre		or's Namo	(First, Middle, I			
rked ot tic ever	To Be	Ralph Walling						lelli			aine)	
7 is ma trauma	-	19a. Informant's Name/Relationship (T		ughter)	1	-			aldorf,		n, State, Z 0601	ip Code)
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nt: If		1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State A	rlingto	on Natio	nal Ge	mete	2007 ry A	rling	ton,	Virginia
Important: If Item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Licens	MO	1464					Funeral		-	6633 01d 20735
sician and brighted and miner and main and miner and min	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any keating to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consequence or a consequence or as a consequence or a consequence or a consequence or a consequen	neuce of):	<i>y</i> / 10	wc XY					Jon med 37
certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 24☐No 9 ☐ Unknown	1 Live	tcome pf pregna birth 2 Peta nant at time of c	al death 3	⊒Ectopic pregna ⊒ Other (specify)					Date of deli	very Day Year
signed b d be det	þ	Part II. Other significant conditions co	entributing to o	eath but not res	ulting in the u	nderlying cause	given in Part	l.	23e. Did tol			the cause of death
s has beer ge 2 shou	Completed								24a. Was a autops perfori	sy .	b. Were au prior to c death? 1 ☐ Yes	topsy findings avails completion of cause 2 \(\sum \text{No} \)
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er this certificate eral director, pa	15	1 Natural 5 Pending 2 Accident investigation	(Moi	nth, Day Year)	Injury	V	lorƙ? □Yes 2□					
r: After this certificate ne funeral director, pa	讀	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)									mber or Ru	ral Route Number,
I Director : After this certificate d in by the funeral director, pa	ertification		80		owledge, deatl	h occurred at the	time, date a					
ne Funeral Director: After this certificate sletely filled in by the funeral director, par	edical Certification:	29a. Certifier (Check only one) 1 Certifying Phy	iner: On the b				y opinion, de	ath occurr	od at the time, d	ato ana piac	e, and due	to the cause(s)
To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical Certification	(Check only 2 Medical Exam	iner: On the b	asis of examina	ation and/or in	vestigation, in m	nse number		2	9d. Date sin	ned (Month	1. Day. Year)
To the Funeral Director: After this certificate completely filled in by the funeral director, pa	edical	(Check only 2 Medical Examone) 29b. Signature and Atle of Configure	iner: On the t	asis of examina	ation and/or in	vestigation, in m	nse number		2	9d. Date sin	ned (Month	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Nancy 11:40PM 07 31 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Eierman Avenue Baltmore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 0+123 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗶 F Months Hours Min 54 MD 215.64.9422 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at "natural", or items 23a or 28a-f sh odical Examiner must be notified NIA 1 XYes 2 □ No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA tierman tvenue permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural". or Health and Injury or other trainment. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Ketail 12th arade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mont 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yvette Cox Baltimore MD 21212 Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 08/24/21 Windsor Mill, MD 21. Signature of Funeral Service Licens Vaughn C. Greene Tuneral Services 4905 York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes certificate 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 1 Inpatient 3□ DOA P this 28a. Date of Injury funeral 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours el 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature 29d. Date signed (Month, Dav. Year)

State Registrar

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division or Vital

101

32. Registrar's Signature

Year)

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2007

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 1247 AM Christian Floyd R. August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore pital 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 → M 2 □ F **Director** 60 212-44-7428 07 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Ex-miner must be notified at Y∏Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5114 Chalgrove Ave 21215 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🐉 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Childrens Hospital Technician Department of Hearth and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be John A. Christian Nancy Pryor ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Date 20c. Location - City or Town, State Lavita Christian-Wife 20a. Method of Disposition Baltimore, 1☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 8/8/07 Randallstown, Md permit. 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee Maham 21215 4300 Wabash Ave, Baltimore, Md 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a onsequence of): /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Metastatic attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 1 X Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determit 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after dear To the Funeral Directo completely filled in by the

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

State

Registrar

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w

vai Hospital
32. Registrar's Signalure nal of Ba

Come

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2⁰3 July 2007 George Marshall Copeland 12:55 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 ☐ F Director 250-20-6282 83 1,1923 South Carolina Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 No Director Maryland Columbia Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21046 9532 White Spring Way U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. within 72 hours after 1 **2**Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify þ 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Merchandising es 1 and 2 should be filed w of Health and Mental Hygie f item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Copeland Pattey Wall 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Copeland (Son) 9532 White Spring Way Columbia, MD 21046 permit. Pages 1 a
Department of Hei
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 ☐ Other (Specify) Catonsville, Maryland 7-31-2007 21. Signature of uneral Service License Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. As only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition LUN YZAAS Physician resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner P.O. Box 68760, law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of) attending physician for use as the buna Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signated by page 2 should b 2 🗌 No 3 Probably 4 □Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No 24a Was an 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HDSP14 1 ☐ Yes 2 📉 No 10 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, spital or Attendi nours after death. neral Director: A

within 24 hours at To the Funeral D completely filled i 10x1

Medical 29b. Signature and title of certifier DANIEUE DOBERMAN IMD

29c. License number 764395

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N. CHARLES ST, SUITE 216, BALTIMORE, MD 21204

31. Date filed (Month State Registrar

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 20b. perFH.g870, 8/15/07 TT Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Dashiell Jane 3151 2.05 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number City. Town, or Location of Death Examiner Baltimore 60 spita If Under 1 Year] If Under 24 Hrs. . last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yr **Funeral** Months Days Hours 219.05.335 1 □ M 2 X F MD Director 04107 Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Wicomico 1 ☐ Yes 2 No askin Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be n USA Capitola Road 21865 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ۵ Specify: Black 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Cook Public Schools 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Jones 19a. Informant's Name/Relationship (Type: Plint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Kudolah Lane Salisbun 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematon 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Compassion Funcial 7. Pron 119-121 S. Stricker Street Part . Enter the disease, or complicitor is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one leads to one each line. Approximate Interval Between Onset and Death bleed Immediate Cause (Final bral **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any least termination cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) and the burial-tra Due to (or as a consequence of) Box 68760 physician as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 2 □ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 10 24a. Was an autopsy After this certificate 1□ Yes 2[Division or Vital Hospital or Attending Physician: 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 3□ DOA Certification: To 2 ER/Outpatient Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) BARAHONA 5707 30. Name and address of person 31. Date filed (Month, Day, Year) State

Registrar

AUG 0

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DAS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ellen B.E. Dotson 4/4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex Days 1□M 2∏F 220 34 7887 88 Yrs. Director Nov 26, 1918 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mential Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c, City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9228 Piscataway Road 20735 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No þ Specify: 3 Vidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nolan J. Douglas Ellen R. Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inez T. Pickeral (Daughter) 9228 Piscataway Road, Clinton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ţ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Aug 7, 2007 Clinton, MD 21. Signature of Enheral Service/Licensee 22. Name and Address of FacilityLee Funeral Home, Inc. 6633 Old MU139 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepatocelluar Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate outco. Enter the defining Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Year 4□Pregnant at time of death 5 Other (specify) signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy page performed' 2X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ∏ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No P 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: 24 hours a

Marýland 21215-0036

Baltimore,

State

29a, Certifier

(Check only one)

31. Date filed (Month, Day

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Martin Weltz,7525 Greenway Ctr Drive, Greenbelt, MD 20770

Date filed (Month, Day, Year)

29c. License number

D 23743

29d. Date signed (Month, Day, Year)

Aug 1, 2007

Physician /Medical Examiner

Funeral Director

State of Maryland / Department of Hear Registrar State of Maryland / Department of Hear Certificate of De	alth and Me	•	ne	
Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Margarete Ehrlich		August	1, 200	7 6:55 A M
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death		4c. County of I	Death
	y Chase		Montgo	omery
1 □ M 2 X F O S Months Days F	Hours Min.	 Date of Birth (Month, Day, Ye 	ear)	Birthplace (State or Foreign Country)
Usual Residence of Decedent	2	September 28	3, 1915 A	ustria
10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland Montgomery Chevy Chase				1 □Yes 2X No
10e. Street and Number 10f. Zip Code	-	10g.	Citizen of Wha	it Country?
9006 Kensington Parkway 20815		U	nited S	tates
11. Marital Status 12. Was Decedent Ever In U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	anic Origin? (Spec Mexican, Puerto R	cify Yes or No- Rican, etc.)		American Indian, White, etc.
_ If Yes, Give 1 Li Yes 2 Ma No S	Specify:		Specify:	White
3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	nn	161	. Kind of Busin	ess/Industry
(Specify only highest grade completed) (Give kind of work done during life, DO NOT use retired)	ing most of working	g Na		Institute of
Elementary/Secondary (0-12) College (1-4or 5+) Physicist		St	andards	s and Technology
17. Father's Name (First, Middle, Last) 18.	3. Mother's Name	(First, Middle, Mai	den Surname)	
Josef Ehrlich	Charlot	te Koba	k	
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and	d Number or Rural	Route Number, C	ity or Town, Sta	te, Zip Code)
Gertrude Ehrlich /Sister 6702 Wells Parkv				
20a. Method of Disposition 1 ☐ Burial 2 ፟MCremation 3 ☐ Removal from State	August	t 2,	c. Location - City	y or Town, State
4 □ Donation 5 □ Other (Specify) Montgomery Crematorium, II	nc. 2007	Be		Maryland
21. Signature of Funeral Service Licensee Mugalette Days M01305 22. Name and Address of Robert A. Pumph 7557 Wisconsin	of Facility Prey Funera Avenue, Be	l Home/Bet thesda, Ma	thesda-Ch ryland 20	evy Chase, Inc. 0814-3501
23a. Part1. Error the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or least failure. List only one cause on each line. Immediate Cause (Final disease or condition Diabetes Mellitus	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death Years
disease or condition resulting in death) DIADELES MELLITUS Due to (or as a consequence of):				Tears
Multi-organ Failure				Years
Sequentially list conditions, farty, had not be in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting death) lest				
Cause (Disease or injury that initiated events resulting in death) Last				Years
Due to (or as a consequence of):				
d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		- Sidili	23d. Date of Month	f delivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I.	23e. Did tobac	co use contribu	te to the cause of death?
Dementia, Dysphagia		1 ☐ Yes	2 No 3	∃ Probably 4 🔀 Unknown
		24a. Was an autopsy	prio	re autopsy findings available r to completion of cause of
		performed 1 Yes 2 🖸	l? dea No 1□	tn? Yes 2□ No
examiner?	6. Place of Death			
1 ☐ Yes 2 🕅 No		e 5 Residence		Specify)
1 🕅 Natural 5 🗆 Pending (Month, Day Year) Injury Work?	s 2 No	od. Describe now	injury occurred	
3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office		Bf. Location (Stree	t and Number o	or Rural Route Number,
4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	tate)	
29a. Certifier (Check only one) CertifyIng Physician: To the best of my knowledge, death occurred at the time, (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion and pen	date and place, ar ion, death occurre	nd due to the caus d at the time, date	e(s) and manne and place, and	er as stated. I due to the cause(s)
29b. Signature and title of certifier 29c. License nu	umber	29d.	Date signed (A	Month, Day, Year)
30. Name and address of person who complete cause of death (Item 23a) (Type, Print)	- (0	1	/
Raman R. Tuli, M.D. 10810 Darnestown Road, Sui	te 202.	Gaithers	burg. M	arvland 20878
31. Date filed (Month. Dav. Year) 32 Registrar's Signature	,		- 0,	20070
AUG 0 3 2007 June It Sparle				

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State

Registrar

			for State	State of Maryland	•	rtment of H		Mental Hy	2.11	87	01179
			Registrar		Cer	uncate or i	Dealii	2. Date of De	Reg. No.	- 1	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Li	ist)				Month	Day	Year	11 32 P M
	/Medic		Dorethea	Н.		Fost		12024		ty of Death	11 261
	Examin	ier	4a. Facility Name (If not institution, gi	e street and number) GeN	esis	0	r Location of Deat			•	
			1100 YORK	RS/MUITI-Me	dical	Balto If Under 1 Year	Md - 21 If Under 24 Hrs.	204 8. Date of Bir		TO.	place (State or Foreign
	Funeral			Sex 7. Age (In yrs. la 1 ☐ M 2X F	Yrs.	Months Days	Hours Min.	(Month, Da	ıy, Year)	Cour	ntry)
l,	Director		217-12-0796 Usual Residence of Decedent	88				04 10	19		MS
	and		10a. State 10b. County	10c. City	, Town or Loc	ation				1	IOd. Inside City Limits
	f sho	ō	MD NA		Balti	more					1 XYes 2 No
	the t	Director	10e. Street and Number		Dartr	10f. Zip Code	-		10g. Citizen of	What Cour	ntry?
	with a or						1015				
	death with the Maryland ms 23a or 28a-f show Frinst be routified at	Funeral	5904 Bland Ave	12. Was Decedent Ever in U.S	S. 13. W		1215 ispanic Origin? (S	pecify Yes or No		J.S.A	
	Item Item	'n	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🛣 No	lf	/as Decedent of H Yes, specify Cuba	an, Mexican, Puer	o Rican, etc.)	Bt	ack, White,	etc.
0000	within 72 hours after ene. than "naturel", or Ite ite Medical Eraciline	by I	3 ☐ Widowed 4 【X Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Spec	ity: Bl	.ack
ş	2 hou		15. Decedent's B	ducation	16a. Deced	ent's Usual Occup	ation	, .	16b. Kind of	Business/In	dustry
2	n n	Completed	(Specify only highest gi	College (1-4or 5+)	(Give F	and of work done of NOT use retired	during most of wo d)	rking	Balti	nore	City
	with iene r tha	E o	12th grade	na		Health	Aide		Healtl	n Dep	ot.
0	be filed within 72 hours after death with the Marylan tall Hygiene. Tall Hygiene. The Madical Evan bar must be routined at event, the Madical Evan bar must be routined at	BeC	17. Father's Name (First, Middle, Las	1)			18. Mother's Nar	me (First, Middle	, Maiden Suma	ıme)	
<u>a</u>		To B	James Dunstan				Mabel	Hughle	ett		
2	2 should be and Mental Is marked e	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street				n, State, Zip	Code)
<u> </u>	D = 1 = 5		Linda Bryant-D	aughter	5904	Bland	Δυρ. Β:	1+imor	ρ. Md	212	15
ō,	s 1 and 2 should f Health and Mer item 27 is marke other treumetic		20a. Method of Disposition	20b. Pl	ace of Dispos	ition (Name of atory or other place		Date	20c. Location		
9	Pages nent of int: If it iny or o		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Spec	_Removal from State		Memori		8/6/0	7 Arhi	1110	Md
Saltimoi			21. Signatura of Funeral Service Lice			Name and Address		2 0/0/0	/ ALD	Lusi	M
Ö	permit. Departn Imports any inju		Blimin	B Kake				50161		M -7	21215
			23a. Part 1. Enter the disease, or con shock, or heart fail fre. List only	plications that caused the death	. Do not ente	00 Waba	g, such as cardia	or respiratory a	more, rrest,	Ma	21215 Approximate
			shock, or heart failure. List only Immediate Cause (Fina)								Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. DEMEN Due to (or as a consequ	TIA		_			1	nonen
	Examiner						~ ~ ~	10			nonto
			Sequentially list conditions,	b. CONGEST	TIVE	HE	ART	PHICL	KE	/	vicium
	ed ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				1	-0-01	-		Months
D	and and I-trar	хап	that initiated events resulting in death) Last	CORON AR	ence of):	PATER	4 013	EASE		/	viorus
Š	be exician buria	<u>~</u>	Q.	FAILURE		10 7	HRIV.	_			
0/0/	certificate be executed adding physician and use as the burial-transit	dic	•	d. Tritorice		, ,					
o XO	leath certific attending p	iclan/Me	IF FEMALE:	23c. If yes, outcome of pregnar	nev				224 0	ate of delive	201
0		lan	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				fonth	Day Year
	the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	aui 5	Other (specify)					
7.	hat the deby detac	Д.	Part II. Other significant conditions	contributing to death but not resu	Iting in the un	deriving cause give	en in Part I.	23e. Did 1	obacco use co	ntribute to the	he cause of death?
Ś	v requires that the death been signed by the atte should be detached for	by				,		10	Yes 2□No	3 ☐ Prot	pably 4 Donknown
ecords	requ	ompleted							104		
ည	25 3	npl			-	-		24a. Was		prior to co death?	psy findings available mpletion of cause of
	The I	Cor						1 ☐ Yes	2 No		2 No
VII a	ysician: is certific director,	Be	25. Was case referred to medical examiner?					ath (Check only	one)		
2	> .9 D	은	1 ☐ Yes 2 ☐ No		ER/Outpatient		4 Jaursing F	lome 5 Resi			y)
	ng Ph fter th	on:	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe	how injury occu	ırred	
0	endi eath. or: A he fu	cati	2 Accident investigation			M 1	Yes 2 No				
JIVISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not 1 4 ☐ Homicide determined		me, farm, stre)	et, factory, office		28t. Location (City or To		iber or Rura	I Route Number,
	itel o										
	Hosp 24 hou Fune tely fill	edical	(Check only 2 Medical Exe	hysicien: To the best of my know miner: On the basis of examinati	vledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	e, and due to the erred at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
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			30. Name and address of person who		23a) (Tuna F	Print)	0-31	راد		Test.	2/10
	9		Shakunma	0 0 1	-C C	1650	sant	a90	Rd	0011	mhie
	Sta	te	31. Date filed (Month, Day, Year)	32. Ragistrar's Signat	ure			J	/	40	7,0015
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			State of Ma	aryland / Depa			/lental Hyg	giene			
			Registrar	Ce	rtificate of	Death ————	T	Reg. No.	011	91:9	13
t	Physici	an	Decedent's Name (First, Middle, Last)	_			2. Date of Dea Month	Day	Year	3. Time of Dea	ath M
	/Medic Examin		Maiya 4a. Facility Name (If not institution, give street and number)	Fra	zier	r Location of Death	Jur	2c, Coi	2007 unty of Death	0413	
1	Examin	ei	The Johns Hopkins Hose	rita 1	12 11.	ore			NA		
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)			8. Date of Birth (Month, Day	1		lace (State or Fo	reign
	Director		NA 1□M 2₹F	Yrs.	I Days	riodis Will.	7–28-		Cou	Md.	
	land t		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				11	0d. Inside City Li	imits
	Mary -f sho iied a	tor	Md. Charles	Waldo	orp					1 □ Yes 2√2	
	h the r 28a r noti	Director	10e. Street and Number	-	10f. Zip Code			10g. Citizen	of What Cour	itry?	
	th wit 23a c 1st be		2634 Recess Ct.		2060	03		US	A		
	tems	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of H if Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14.	Race - Americ Black, White,		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by F	1 Never Married 2 Married 1	lo	1 ☐ Yes 2 ☐ No	Specify:				ack	
Ş	2 hour	edk	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind o	of Business/Inc	lustry	
21215-0036	hin 72 e. an "na Medi	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	life.	kind of work done of DO NOT use retired	during most of work d)	<i>i</i> in <i>g</i>			200117	
	ed wit	Completed	Infant NA		fant			NA			
nd	S should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last) Michael A.	Frazie		18. Mother's Nam Danie			_		
3	should and Men s marke umatic	ှ		-					IcCoy		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		<pre>19a. Informant's Name/Relationship (Type. Print) Michael & Danielle Frazier</pre>		ng Address (Street						
	s 1 and 2 of Heaith a item 27 is other trau		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Date Date		on - City or To		
Baltimore,	permit. Pages 1 Department of F Important: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	matorý or other plac O Miss. Cl	΄ ; ο	3-07	Cair	Ga.		
aĦ	permit. Departm Importal any inju	- 1	21. Signature of Funeral Service Licensee		2. Name and Addre		arch F.H				
0	B III De		Lenant M Thorper	/ 1	1101 E. No	orth Ave.	., Balti	more,	Md.	21202	
þ			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ent e.	ter the mode of dyin	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between	
9	Physician		Immediate Cause (Final disease or condition resulting in death) a. Pur Mon	ARY HEI	MORRHAUM	€				Onset and Deat	
	/Medical Examiner		Due to (or as a	consequence of):						27 House	ė.
		e	Sequentially list conditions, b. EXTREN	AC PRE	MATURITY					21 .500	2
b.	uted d ansit	Examiner	Sequentially list conditions, if any leading to in modular cause. Enter Underlying Cause (Disease or injury that initiated events	RH AUG						12 Hose	-\$
0	an an rial-tr	Exa		consequence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d								
9	ertific ling p	Mec	IF FEMALE:								
Box	death certific attending p	ian	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	,		23d.	Date of delive Month	ery Day Year	r
o	the de	Physician/Me	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at 1 9 ☐ Unknown 9 ☐ Unknown	ume or death 5	Other (specify)				Jay	28 200	57
Ω.	w requires that the d been signed by the should be detached	y Ph	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use d	contribute to the	e cause of death	1?
Vital Records,	quires n sign	ed by					1 □ Y	es 2⊠N	o 3 ☐ Prob	ably 4 ∐Unkn	iown
၀၀	aw re	Completed					24a. Was a		4b. Were auto	psy findings avail	lable
m m	The lav ate has page 2:	E			_		autops perfor 1□ Yes	med? 2 No	prior to con death? 1 ☐ Yes	npletion of cause 2⊠ No	101
/ita	sician: The certificate harector, page	Be	25. Was case referred to medical examiner?			26. Place of Deat		/			
or o	Physical this call dire	ို	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatien 27. Manner of Death 28a. Date of Injun			4 LI Nursing Ho	me 5 Reside)	
U _O	ding After funer	ion	1 Natural 5 Pending (Month, Day	y 28b. Time of Injury	Worl	y at k? Yes 2 □ No	28d. Describe ho	ow injury oc	curred		
Division or	Atten deatl octor: y the	fical	3 Suicide 6 Could not be determined 28e. Place of injur	ry - At home, farm, str			28f. Location (Si	treet and Nu	umber or Rura	l Route Number	
Š	al or safter	Certification:	4 Homicide determined building, etc.	(Specify)			City or Tow				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.		29a. Certifier 1⊠ Certifying Physician: To the best of (Check only 2 Medical Examiner: On the basis of	f my knowledge, death	h occurred at the tin	ne, date and place,	and due to the c	ause(s) and	manner as s	ated.	
	the H in 24 the F mplete	Medical	and manner stat	led.							
	with Con.	Σ	29b. Signature and title of certifier		29c. License				gned (Month,		
		-	0	-11 (11 :	RES .	000	`	1009	29,20	~ 1	
	2		30. Name and address of person who completed cause of de	ath (Item 23a) (Type,		STREET	BALTIMO	RE H	VR41 AI	V O	
	Sta	te	31. Date filed (Month, Day, Year) . Registrar	<u> </u>							
. 3	Registra		AUG 0 3 2007	I April	w						

07-05870

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

isa Furkan	1- For State	of Maryland / Depart <i>Certi</i>	tment of Healtr ficate of Death	_	giene	No	
Physician/	1. Decedent's Name (First, Middle,Last				2. Date of Death		3. Time of Death
Medical Examiner	Lisa 4a. Facility Name (if not institution, give	Furk		wn, or Location of Death	Month [August 1, 2	007 4c. County of De	0417 hrs
	7356 Geise Ave	e street and number)	Edgen			Baltimore C	
Funeral Director		x 7. Age (In yrs. las	Months		8. Date of Birth	For	Birthplace (State or reign Country) Maryland
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
≱ .	Maryland Baltimo	re	Egdemere				1 Yes 2 XNo
the Maryland a or 28a-f sh lifted at once	10e. Street and Number		10f. Zip (· 10g	. Citizen of What C	Country?
ith the 23a or notific	7356 Geise Avenue	12. Was Decedent Ever in U.S.	13 Was Deceden	21219 t of Hispanic Origin? (Spe	ecify Yes or No-	USA	nerican Indian, Black,
er death with the critical state of the crit	1 Never Married 2 X Married		If Yes, specify	Cuban, Mexican, Puerto	Rican, etc.)	White, etc	
after d		If Yes, Give Year	1 Yes 2			and the later of the	White
hours hatur Exam	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	Ny highest grade completed) College (1-4 or 5+)		ccupation (Give kind of wing life, DO NOT use retire		6b. Kind of Busine	ss/Industry
5-0036 ed within 72 hours aft lygiene. other than "natural" le Medical Examine Completed by	12 years	College (14 til 31)	Waitress			Restaur	ant
215-0036 be filed within 7 nial Hygiene. rked other than rent, the Medica Be Comple				18.Mother's Name	,	niden Surname)	
2121 bould be fil d Mental (d is marked tic event,	Michael Kelly 19a, Informant's Name/Relationship (T	vpe. Print)	19b. Mailing Address	Helen Sc (Street and Number or R		er, City or Town, S	tate, Zip Code)
MD 2 shot alth and I m 27 is:	Muhammad Furkan	Husband		Avenue, Ed	gemere,	Maryland	21219
	20a. Method of Disposition 1 X Burial 2 Cremation 3		ace of Disposition (Name ematory or other place) Lawn Cemet	Augu	st 4,	20c. Location - City	
Baltimore, permit. Pages I a Department of He Important: If ite	4 Donation 5 Other Specify			_ _	007	Dundalk,	
Ball permit Depar Impo	Signature of Funeral Service Licen	molly	Connell	Address of Facility Y Funeral H Ollers Point	ome Of I	Dundalk,P	.A. d. 21222
Physician	23a Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the death. I	Do not enter the mode of	dying, such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Medical aminer	Immediate Cause (Final disease a.	Narcotic intoxica					Death
1	Sequentially list conditions, b.	Due to (or as a consequence of).					
iner	if any, leading to immediate	Due to (or as a consequence of)					Į.
led nsit Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)					
60, ate be executed hysician and be burial - transit Medical Ex:	d. X UNPENDED						
60, ate be c hysicia e buria	IF FEMALE:	#23a,27,28a-f, pe	erME, <u>g8/U, 8/8</u> ancy	3/0/ TT	-	23d. Date of deli	ivery
687 certific nding p se as th	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of dea	2 Fetal death	3 Ectopic pregna	ncy	Month	Day Year
Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be execut as after death. In Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - tra errification: To Be Completed by Physician/Medical	1 Yes 2 No 9 V Unknown		th 5 Other (Spec	rry)			
P.O. I that the ned by the detache		contributing to death but not res	sulting in the underlying	cause given in Part I.			e to the cause of death? Probably 4 ✔ Unknown
IS, P quires t en sign Lid be d		 -			1 24a. Was a		e autopsy findings available
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al Re an: The ertificate ttor, pag.			2	6.Place of Death (Check	1 Yes 2	✓ No 1	Yes 2 No
F Vita Physicia or this cer ral direct	examiner?	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 D	OA Other Nursin	g Home 5 F	Residence 6 🗸 C	Other: Scene
ing Pt. After After funeral		(Month, Day,Year)	28b. Time of Injury 2	8c. Injury at Work? 1 Yes 2 Y No		ow injury occurred	
ivision I or Attend after death. Director: d in by the f	2 Accident 5 Pending Investigat	28e Place of Injury - At hou	Fnd 4:09 am me. farm. street, factory.		unk 28f. Location (S	treet and Number o	r Rural Route Number, City
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 X Could not determine	be	_		7356 Geis	ete) Se Ave. Edge	emere, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi-Medical Certification: To Be Completed by Physician/Medical E.		ian: To the best of my knowledg r:On the basis of examination an and manner stated.	e, death occurred at the d/or investigation, in my	time, date and place, and opinion, death occurred a	due to the cause at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
F » F »	29b. Signature and title of certifier	msp.	290	License number O.C.M.E.		29d. Date signed August 1, 200	
Ja	30. Name and address of person who		23a)	O.O.IVI.L.		, tugust 1, 200	
0	Ling Li, MD Assistant M	111 dedical Examiner	Penn Street, Baltir	more, MD 21201	<u></u>		
State Registra		32. Figistrar's Signatur					
			~				

07-05661 Evans Fringrong

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Evans Frinprong	1- For State Registrar	Sta	ite of Maryland		rtment of hificate of		and i	vientai		Reg. No.		07 2487
Physician/ Medical Examine	1. Decedent's	s Name (First, Middle Vans	Last) Frinprong						2. Date of De Month July 23, 2		Year	3. Time of Death 1800 hrs
Wedical Examine			, give street and number)		4	lb. City, To	wn, or Loc	cation of De			County of Dea	
4		Chesapeake Me				Belair		•			larford	
Funeral Director		54-3686	6. Sex 7. Age	e (In yrs. Ia:	st birthday) Yrs.	If Under Months		If Under 241 Hours N	Irs. 8. Date of B June		Fore	Birthplace (State or eign Country) Ghana
The state of the s	Usual Reside	nce of Decedent 10b. County		10c. City,	Town or Locati	on						10d. Inside City Limits
3	New Yo	ork B	onx		Br	onx						1 X Yes 2 No
the Maryland a or 28a-f show tified at once. Director	10e. Street a	nd Number				10f. Zip (ode		300	10g, Citi:	zen of What Co	ountry?
th the 33 or notifie			losholu Pkwy	Francia III 6	2 142 Wa	Decador	of Hiopa	olo Origin?	Specify Vec or N	10	USA	erican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To 'Ba Completed by Funeral Director		Married 2 Ma	12. Was Decedent Armed Forces? 1 Yes 2 proced If Yes, Give Year		If Y		Cuban, M	lexican, Pue	Specify Yes or Nerto Rican, etc.)	10-	White, etc.	
ours after an incention of the control of the contr			or Dates: ify only highest grade con	npleted) ·	16a. Deceden	t's Usual C	ccupation			16b. I	and of Busines	s/Industry
5-0036 ed within 72 hour lygiene. other than "natu he Medical Ixan	Elementar 1	ry/Secondary (0-12)	College (1-4 or	5+)		Music	ian	3			Music	
215-0 be filed v be filed v intal Hygi riked othe ent, the J		Name (First, Middle, Kofi	,	fori			18.		ame (First, Middle NES		Surname) rimponn	na a
212 ould be d Ments s mark its even		nt's Name/Relationsh						nd Number	or Rural Route N	umber, C	ity or Town, St	
MD d 2 sho tth and tth and in 27 is	Nana	Apraku							wy, Bron			or Town, State
ore, es l an of Hea If iter		of Disposition 2 Cremation	3 Removal from St	ate c	Place of Dispos rematory or oth	her place)			August			
ti Pagi t. Pagi timent rtant:	4 Donat	tion 5 Other So	ecify:	Mu	nicipal				2007 Stalling		rra, Gh	
Bal permi Depar Impo injur	21. Signature	or Funeral Service	Licensee						. Pasade			
Physician	23a Part I. E	Enter the disease, or List only one cause	complications that caused									Approximate Interval Between Onset and
/Medical aminer	Immediate C	Cause (Final lisease	Viral syndr			ng hyp	ertens	sive ca	rdiovascul	ar di	sease	Death
`		resulting in death)	Due to (or as a cons	equence of):							
100	if any, leading	r list conditions, ng to immediate er Underlying Cause	Due to (or as a cons	equence of	·):							8
uted of graning the samingr		injury that initiated ting in death) Last	Due to (or as a cons	equence of	j):							
50, we take the executed with	XUNPE	NDED	AMENDED .27.	perME.	 g870.8/	3/07 T	Т					
ox 687(ath certifica attending pl or use as the	23b. Was dec	cedent pregnant in th	e 1 Live birth 4 Pregnant at	me or pregr	₂ Fe	etal death ther (Spec	3	Ectopic pre	egnancy	23	d. Date of delive	very Day Year
D. BC the der by the sched for Days			ons contributing to deat	th but not re	esulting in the i	underlying	cause give	en in Part I.	23e. Dio	tobacco	use contribute	to the cause of death?
P.C.	3								_ 1 \ \	'es 2	No 3 F	Probably 4 🗹 Unknown
Records, The law require. ficate has been sign, page 2 should be										opsy	prior	autopsy findings available to completion of cause of
Recc The lav										formed?	death	
cian:	ນ 25. Was cas	e referred to medical	Unanital:	- [2			10	hor:	eck only one)	7		
Physical direction	27 Manner		i inpatr		ER/Outpatient 28b. Time of			at Work?	ursing Home 5 28d. Describ		ence 6 O	ther:
on o anding ath. rr: Aff he fun	1 X Natu	ural 5 Pend		Year)			1 Ye	s 2 No				
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Finneral Director: After this certifi completely filled in by the funeral director,	2 Accid	ide 6 Coul	d not be mined (Specify)	njury - At ho	ome, farm, stre	et, factory,	office buil	Iding, etc.	28f. Location or Town		and Number or	Rural Route Number, City
To the Hospita within 24 hours To the Funeral completely filler		1 Certifying Pl	nysician: To the best of miner:On the basis of exa	ny knowled amination a	ge, death occu nd/or investiga	rred at the ition, in my	time, date opinion, c	and place, leath occurr	and due to the cared at the time, da	ause(s) a ite and pl	nd manner as s ace, and due t	stated. the cause(s)
2	29b. Signate	re and title of certifie				290	License I			- 1	- '	Month, Day, Year)
3 A		arol	-Hall	do			O.C.M	.E.		Jul	y 24, 2007	
OK Dear			who completed cause of sistant Medical Exa		23a) 111 Penn	Street, F	Baltimor	e, MD 2	1201			
Stat		d (Month, Day, Year)	32: Registra	ar's Signat		A				_		
Registra		MILETER	2007 Juliane	-	A PARTY	Comment						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Depedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3:38M WA NE 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Northwest Hospital Baltimore Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 11–16–1953 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 □ M Hours 380-82-6180 53 Nigeria Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 No Md. 10e. Street and Number Owings Mills Baltimore 10f. Zip Code 10g. Citizen of What Country? 14 Enchanted Hills Rd. Apt. 101 21117 Nigeria 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Nigerian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nigeria 12th grade 17. Father's Name (*First, Middle, Last*) Policial Advisor Master's Deq Edo State Gov't. 18. Mother's Name (First, Middle, Maiden Surname) Peter Giwa Unkn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type. Print) Ogie Odiase 14 Enchanted Hills Rd. Apt. 101, Owings Mills, Md. Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Plot 9-1-07Ugboha, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East wan 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final JER resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 3 ☐Ectopic pregnancy Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 IInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner The law requires that the death certificate be executed burial-transit and Division or Vital Records, P.O. Box 68760. attending physician as the use for detached the þ signed pe

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

items 23a

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"natural"

traumatic event, the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than any Injury or other traumatic event, the Me

Physician

within 72 hours after death

3altimore, Maryland 21215-0036

at

Director

Funeral

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Completed

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Examiner must be notified

been has page 2 this certificate filled in by the funeral After death within 24 hours after death To the Funeral Director:

or Attending Physician;

Physician/Medical Be

þ Completed

Examiner

Certification: To

cal

Med

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation

6 Could not be determined

5

State Registrar 29b. Signature and title of certifier

and manner stated.

29c. License number

1 Yes 2 No

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print)

Strub F. 31. Date filed (Month, Day, 019 Fullis DWD. 32. Registrar's Signature

3 2007 AUG 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Ам thishaw 31 tricia 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DMMC Raltmare If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09.22.94 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days .58.8781 1□M 2XF Director mi Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Locetion 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Ever in U.S. Armed Forces?

I □ Yes 2 No
If Yes, Give
Year or Dates: Millington Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Iack 2 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COOK Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walker ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 408 Baltimon mo 31203 A. Millington Ave Michael 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 ☐ Cremation 3 Removal from State Baltimore, MD 08.06.07 Westein 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughn C. Greene funerul Scarce 21. Signature of Funeral Service License. 728 Liberty And Mandallotan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** DISCUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No g□Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Onknown 2 No 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No after death. 2 Accident in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18170 ami Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Baltimore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene

		-	For State Of Maryland		tificate of L			Reg. No.	24878					
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath 31, 2007	3. Time of Death 10:55P M					
	/Medic	al	Fanny Hoffman 4a. Facility Name (If not institution, give street and number)	T	4b. City, Town, or	Location of Death	oury .	4c. County of Dea						
	Examin	er	61 Chelmsford Court		•	ltimore		Balti	more					
337	Funeral Director		5. Social Security Number 215-28-6503 6. Sex 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Feb. 1	9. Bio 6, 1926 Fr	thplace (State or Foreign ountry) ance					
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation				10d. Inside City Limits					
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	ath wi	ral	6907 Moyer Avenue	6 119 1	Mac Decedent of Hi	21234	acify Vas or No	USA 14. Race - Am	erican Indian.					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Warded 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba i □ Yes 2⁄€ No	Specify:	Rican, etc.)	Black, Whi						
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lary	2 short and I is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address <i>(Street a</i>	and Number or Rur	al Route Numb	er, City or Town, State, ldwin Mar	yland ²¹⁰¹³					
e, E	1 and Health em 27 ther t		Paula Mister-daughter 20a. Method of Disposition 20b. F	laca of Dieno	sition (Name of		Date	20c. Location - City of	r Town, State					
Baltimore,	t. Pages rtment of rtant: If it njury or o		20a. Method of Disposition 1 □ Burial 2 \(\mathbb{Q}\)Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Forest Hill, arford Road										
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			· Operlingling			18987		8-1-200	7					
			30. Name and address of person who completed cause of death (Ite	m 23a) (Type	, Print) CH RAVE	NBLID	BALTO.	MD 2123	39					
	St Regist	ate	31. Date filed (Month, Day, Year) ALIC 0 3 2007		alle)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 08 01 2007 11:15a Louise Hughes-Bond /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2414 Liberty Heights Ave Baltimore 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛣 □ F Months Days Hours Min. Director 60 212-48-2753 29 ha MD Usual Residence of Decedent with the Maryland 10c City Town or Location 10b. County 10a State 10d. Inside City Limits Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ex. miner must be notified at Y ☐ Yes 2 ☐ No Director Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death v 2414 Liberty Heights Ave 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 21215 Funeral U.S.A. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status ☐Yes 2☐No Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: ð Black Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Private llth_grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be l and 2 should be fil fealth and Mental H m 27 Is marked oth Louella Miller Steven Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2414 Liberty Heights Ave, Baltimore, Md 21215 Franklin Miller-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 8/6/2007 Randallstown, Md Kinq 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av 21215 300 Wabash Ave, Baltimore, Md Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 1 ☐ Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 4 Nursing Home 3 DOA Residence 6 Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending Natural 5 ☐ Pending investigation Injury 1 ☐ Yes death. 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a within 24 hours a To the Funeral L

State Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Year

29d. Date signed (Month, Day, Year)

			For	State of Ma			nt of Health a	•		•	0100	
			= State Ragistrar			Certifica	te of Death		Rag. N	6-007	24.00	j
	Physici /Medic		1. Decedent's Name (First, Middle, W (LL IA M	HUDDLE	50 N	<u> </u>		2. Date of Month	D		3. Time of Deal	th M
	Examir		4a. Facility Name (If not institution,				y, Town, or Location of	Death	4	c. County of Dea		
			Lorien Nursing 5. Social Security Number 6		e (In yrs. last		Columbia er 1 Year If Under 2	4 Hrs. 8 Date o	f Birth	Howar		eion
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ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State	20b. Place ceme	of Disposition (Natery, crematory of	ame of other place)	Date	20c. l	ocation - City o	Town, State	
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30	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	A. W.				001017		
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Kimberly Ann Hale State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner 0859 hrs Kimberly Ann Hale August 1, 2007 4a. Facility Name (if not institution, give street and number)
3507 Carmel Road c. County of Death 4b. City, Town, or Location of Death **Baltimore County** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Delaware 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 220-04-9806 1 M XXF 39 Country) 27,1968 Feb. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Yes 2XXNo MD Carrol1 Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Shamrock Circle 21157 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items 1 Never Married 2XX Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Divorced If Yes, Give Year ore, MD 21215-0036
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Department of H
Important: If it crematory or other place) Burial 2XX Cremation 3 Removal from State 8/3/07 Metro Crematory Incl Baltimore, MD Donation 5 Other Specify. 21. Signature Fur eral Pervice Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD211 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Atherosclerotic cardiovascular disease Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated The law requires that the death certificate be executed are has been stormed. Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X AMENDED #4a, perME, g8/1, 9/5/0/ #23a, 27, perME, g870, 8/30/07 TI X UNPENDED attending physician or use as the burial -Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 be detache 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available s certificate has b autopsy prior to completion of cause of performed? death? 1 ✔ Yes 2 No 1 Ves 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Division of Vital Be examiner? Other₄ - this c Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes After 1 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: within 24 hours after death.

To the Funeral Director: Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Avi. O.C.M.E. August 2, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 32. Figistrar's Signature 31. Date filed (Month

Registrar

2007

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Maryland	-f show	ied at	2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a any injury or other traumatic event, the Medical Examiner minst he master.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760, this

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the burial After 1 within 24 hours after death To the Funeral Director:

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2007 Edward James Harrington 29 July 8:55P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Days Hours 014-07-4970 89 April 29,18 Conneticutt Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Baltimore Catonsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 S. Rolling Road Apt 223 21228 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tyes 2 □ No If Yes, Give Year or Dates: 1 44 - 1 4 5 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🕱 No Specify White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Manufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown) Harrington Bertha Jutras 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Harrington (Wife) 912 S. Rolling Rd. Apr 223 Catonsville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial → 2 Cremation 3 ☐Removal from State 4 Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 8/2/07 Elkridge, Maryland 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral home at MMP, Inc 7250 Washington Blvd. Elkridge, MD 21075 23a. Part 1. Enser the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) schemic Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No was an autopsy performed? 24a Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) No. 2010 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated D 583 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST rowson un 21204 AUG 0 3 2007 filed (Month, Day, 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

			State of Manyland perMD, 18, perTH, C	4Dep		t _I qf H	ealth and	Mental Hy		1000
Physic /Med	lical	1. Decedent's Name (First, Middle, La Christian Buehl	er, Jr.		45 655	Tour or	Leasting of David	2. Date of De Month July 3	Day Year 1, 2007	3. Time of Death 4:00 p M
Exam	iner	4a. Facility Name (If not institution, git 3020 N. Ridge Roa					Location of Deat	n	4c. County of Dea	
Funera Directo	_	5. Social Security Number 6. 212-03-2255	F 7. Age (In yrs. las	st birthday) Yrs.	If Under Months	1 Year	If Under 24 Hrs Hours Min.		th 9. Bir	thplace (State or Foreign ountry) yland
Maryland s-f show ified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Howard		Town or Lo		E11i	cott Ci	ŧу		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the	Dire	10e. Street and Number 3020 N. Ridge Ro	and Apt W104		10f. Zip	Code 21043			10g. Citizen of What Co	ountry?
ore, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural; or Itams 23a or 28s-f show other traumatic avant, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 11∑1Yes 2 □ No If Yes, Give Year or Dates:			dent of Hi cify Cuba		Specify Yes or No to Rican, etc.)		
vital 5-0036 within 72 hours at the natural, or the Madesl Earth	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation a de completed) College (1-4or 5+)	life.	kind of wo DO NDT us	rk done a se retired,	lurina most of wo		16b. Kind of Business	/Industry
Maryland 2121 d 2 should be filed within th and Mental Hygiene. ?? Is marked other than traumatic avent, II a M.	To Be Co	17. Father's Name (First, Middle, Las Christian Buehler		dell	vereu	aut		me (First Middle	automotiv Maiden Sumame) ker maker	e
Maryla and 2 should ealth and Men m 27 is marke		19a. Informant's Name/Relationship Christian J. Bueh	ler- Son	2900	S. L	ake		av i dsonv	er, City or Town, State, ille, MD 21	035
Baltimore, permit. Pages 1a Deportment of Her mportant: If Itam my injury or other more.		20a. Method of Disposition 1 □ Burial 2X □ Cremation 3 [4 □ Donation 5 □ Other (Special Content of the Conte	Removal from State	ce of Disponetery, crer o Cre:	natory or o	ther place	8/2/	Date 2007	20c. Location - City or Baltimore,	
Baltimore, Mages 1 and 2. permit. Pages 1 and 2. Deperment of Health at Important: if Itam 27 is any injury or other trau		21. Si nature of Funeral Service Lice	nsee	6	2. Name an 415 B	d Addres	s of Facility M	lller-Di Baltimor	ppel Funera e, Maryland	1 Home Inc. 21206
Physiciar /Medica Examine		23a. P. rt1. Ther the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (our si conseque)	e/E nce of): TE/) C			TERO	2	
, P.O. Box 687 that the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal di 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pr Other (sp				23d. Date of de Month	livery Day Year
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f Vital Records, ysician: The law requires t is certificete has been signe director, page 2 should be	Completed by	CONGESTI	VP HEAR	27	FA	700	YRE	24a. Was auto perfo 1 ☐ Yes	an 24b. Were a prior to death? 2\int No 1 \sum Yes	utopsy findings available completion of cause of s 2 \square No
of Vital F Physician: Th r this certificete	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatier	nt 3 DC	Othe	ir.	ath Check only		
on o	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 21 (Month, Day Year)	8b. Time of Injury		8c. Injury Work		-	idence 6 Other (Spe	юту)
Division ospital or Attending hours after death. Inneral Director: After y filled in by the fune	Certific	3 Suicide 6 Could not l		e, farm, str	eet, factory	, office			Street and Number or R wn, State)	ural Route Number,
Divisit To the Hospital or Attend within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	edge, death in and/or in	n occurred vestigation	at the tim	e, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	Cehhna	n,	m	License	D-50	184	29d Dave signed (Mon	in, Day, Year)
15		THANNA K	completed cause of death (Item 2)	N	Frint 8	66	ark	BRWI	V Rd, 81	KRIDGE
S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 0 3 20	Registrar's Signatur	TO SOL	age of					

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State of Maryland	Department of Health and Mental Hygiene

- 24		_	1 - State Registrar			Cert	ificate of l	Death		Reg. No.		21.3	. p	
	Physicia	an	1. Decedent's Name (First, Middle, Jenny Andree Hov	,					July 2. Date of De		507 Year	3. Time of 0	Death A M	
	/Medic	al	,			4h Cib. Taura an	Landin of David			County of Death	03.10	A W		
	Examin	er	4a. Facility Name (If not institution, 7832 Fulbright				Bethesda	Location of Death		Montgomery				
	Funeral			6. Sex 7. Age (In yr	s. last birt	hday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9 Birthr	lace (State or	Foreign	
Ы	Director		227-50-9814	1□M 2XF 80	`	rs.	Months Days	Hours Min.	(Month, Da November	25, 19	926 Belg	ium		
	put w		Usual Residence of Decedent 10a. State 10b. County	100.1	City, Town	or Loca	ition				1	0d. Inside City	v Limits	
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	the N 28a-1 notifi	Director	Maryland Montgo	omery		betn	esda 10f. Zip Code			10g. Citi:	zen of What Country?			
	3a or	iO le	7832 Fulbright (Court			. 2	20817		Unit	ed State	S		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S.	13. W		Ispanic Origin? (Si an, Mexican, Puerl		an Indian,				
9	after or Ite		1 ☐ Never Married 2 ☐ Marrie	If Yes, Give			Tes, specify oubli	Specify:	o riiodri, oto.)		Black, White, Specify: White			
Maryland 21215-0036	hours ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	160	Decede	nt'a Haust Ossus	ation						
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212	withi	mo	Elementary/Secondary (0-12) College (1-4or 5+) Operations Analyst							Age	ncy			
٥	e filed Il Hyg other /ent,	Be C	17. Father's Name (First, Middle, L	.ast)	'			18. Mother's Nam	ne (First, Middle,	, Maiden	Surname)			
<u> </u>	uld by Ments Irked Itic e	To E	Albert Leduc					Germain	e Court	in				
lar)	2 sho and l		19a. Informant's Name/Relationsh				,	and Number or Ru			, , , , , , , , , , , , , , , , , , , ,	,		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	rematorium.	a marine			nesda, Ma	-					
g	Depa Impo any i		Impeletto	Barry M0130	5	Rob 755	ert A. Pun 7 Wisconsi	ss of Facility phrey Fune in Avenue,	ral Home/ Bethesda,	Bethe Mary	esda-Chevy 1and 20814	Chase, 3501	Inc.	
			23a. Parti. Enter the disease, or o shock, of heart failure. List of	complications that caused the de	ath. Do n							Approximate Interval Betw	veen	
	Physician		Immediate Cause (Final disease or condition	Metastat	ic B	reas	t Cancer					Onset and D	eath	
	/Medical Examiner		resulting in death)	Due to (or as a conse			4							
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_	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury that initiated events Congestive Heart Failure											
φ. -	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examiner	that initiated events ' resulting in death) Last	C. Due to (or as a conse										
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	rtifica ng ph	Medical	IF FEMALE:		FAIL								e est	
X P P	ath ce ttendi or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg	etal death		ctopic pregnancy	,		2	23d. Date of delive Month	-	'ear	
	he de the a	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 □ Pregnant at time o 9 □ Unknown	of death	5∐(Other (specify)					,		
7.	that t ed by detac		Part II. Other significant conditio	ns contributing to death but not r	esulting in	the und	lerlying cause give	en in Part I.	23e. Did t	tobacco u	use contribute to t	ne cause of de	eath?	
Vital Records,	quires n sign ald be	d by							1 🗆	Yes 2	No 3□ Prol	oably 4 ∏U	nknown	
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<u> </u>	nysician: Th nis certificate director, pag	BeC	25. Was case referred to medical examiner?					26. Place of Dea						
-	sir diji	2	1 ☐ Yes 2 🔀 No		□ ER/Out	<u>. </u>		4 Livuising n			6 □Other (Speci	(y)		
Z Z	ding Ph	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		ime of njury	28c. Injur Worl	y at k? Yes 2 □ No	28d. Describe	how injur	y occurred			
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2	al or / s after al Dire	Certification:	4 ☐ Homicide determin	building, etc. (Spe	ecify)				City or To	wn, State)			
	Hospit 4 hours Funera	edical ((Check only 2 Medical E	g Physician: To the best of my k Examiner: On the basis of exami	nowledge	, death d	occurred at the tirestigation, in my o	me, date and place	e, and due to the	cause(s) date and	and manner as s	tated. o the cause(s)	
28d. Des Unique part of Death 1 Natural 2 Natu										29d. Dat	te signed (Month,	Day, Year)		
											4/24/			
,			30. Name and address of person			Type, P					1 a T	UT		
	12		Celesteann T. B	remer, M.D. 89	001 W		,	enue, Bla	lg. 8, B	ethes	sda, MD	20889		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** WILLIAM LLOYD JONES 10:30 AM August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE GERIATRIC CENTER BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5/23/1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1**⊠**M 2□F 71 316-36-3875 MARÝLAND Director Usual Residence of Decedent 10b. County N/A Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State MD BALTIMORE CITY 1 XYes 2 No Items 23a or 28a-f sh ner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 HOWARD PARK AVE., #217 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21☑ No Specify λq BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) READING TUTOR SELF-EMPLOYED Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FREDERICK JONES KATHERINE PEAKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any injury or other trau
once. ALLAN JONES / BROTHER 6 RETINUE CT. #102, BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State ARBUTUS MEM. PARK 8/08/07 BALTIMORE CO., MD 4 Donation 5 Other (Specify) 22_Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature (A) neral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Inter the sease, or complications that caused the dear o not enter the mode of dying, such as cardiac or respiratory arrest, r heart ailure. List only one cause on each line. Imme rat Cause (Final diseas r condition resulting in death) Sepsis 3 days **Physician** /Medical Due to (or as a consequence of): Examiner Pneumonia ilatera days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Paroxysmal atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Cardiomyopathy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053928 08/01/07 , MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURATYA BEQUM, MD 2434 W. BELVEDERE AVE, BALTIMORE, MD _ 21215 AVE, BALTIMORE, MD -3 Registrar's Signature 31. Date filed (Month, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #26, perVerbal, C870, 8/3/07 Chartificate of Death 2. Date of Death 3. Time of Death Physician /Medical ity Name (If not insti 4b, City, Town, or Location of Death 4c. County of Deat Examiner Dries DMC Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 M 2 □ F 217-90-571 Director Tary land Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh notified Yes 2 No Directo timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. Completed by Funeral Items 2 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 💸 No Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural". er than "natura the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) 7 Is marked other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19b. Mailing Address (Street and Number or 19a. Informant's Name/Relationship (Type. Print) lural Route Number, City or Town, State, Zip Code) permit, Pages 1 and Department of Health Important: If Item 27 any Injury or other troonce. Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licens au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** RO Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho 24a. Was an autopsy performed certificate 2 🔲 or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2N Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Datural 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A 1 Tyes 2 🗌 No death. 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) ork 05 TosePH Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 3 Registrar

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day,

N. Olarles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(IV)

32 Registrar's Signature

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CHAN WES

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8.00g /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner r. Bethe Date of Birth (Month, Day 2 -Social Security Number In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Year Days 1 □ M 2 🗷 🕏 Vrs Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ es 2 ☐ No Directo MI) timore 10e. Street and Number 10g. Citizen of What Country? Funeral Was Deceden 14. Race Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than College (1-4or 5+) ucator 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health Important: if Item 27 i 033 Ohnson 20a. Method of Disposition 1 Magazial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01363 14 1 Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** INJE 0 CARD NFARCT TO /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2 No be detached the 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an has autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗌 Yes 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 24 hours after 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Division or Vital Records, P.O. Box 68760 To the Hospital within 24 hours a To the Funeral L

> 30. Name and ageress of person who completed cause of death (Item 23a) (Type, Print) LIVE 0 32. Registrar's Signature State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year JONES 9:10A M Kulhie 07 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Street N/A N. Laveu If Under 1 Year | If Under 24 Hrs. Social Security Number . Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 1 □ M 2 💢 F Months 240.48.532 NC Director 1933 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits . 28a-f shov notified at Baltimore MD 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 21211 Street N. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Manuland Elementary/Secondary (0-12) Nursing General 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mctachin ည 19a. Informant's Name/Relationship (Type, Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: if it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD 08/03/07 oudon 22. Name and Address of Facility Compassion Funeral Sentices 119-121 S. Stricker Street Baito. MD 21223 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death byt not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an funeral director, page 2 autopsy
performed?

1 Yes 2 No 2 **N**0 25. Was case referred to medical examiner?
1 ▼Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. May er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 💇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17137 MOUNTRy LAW, 30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

DALSHNN.S. SHLV/H 1600 W. DARSHAN.S 31. Date filed (Month, Day, Year) AUG 0 3 20 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	ate of De	ath		Reg	ı. No.		
Physicia	an/	Decedent's Name (First, Middle,Last)					Date of Death Month	Day Year	3. Time of Death	
Medical Exami		Valerie	F	Jone			July 30, 20	07	1726 hrs	
		4a. Facility Name (if not institution, give street and number Franklin Square Hospital	per)	1	ty, Town, or sedale	Location of [Death	4c. County of De Baltimore C		
Funeral			Age (In yrs. last bir		Jnder 1 Yea	ır If Under 2	24Hrs. 18. Date of Birth	(MM/DD/YYYY) 9.	1	
Director		220-80-7068 1 M 2 R	46		onths Day		Min.	- I		
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nd show any ice.	٦	W.3							1 X Yes 2 No	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		10f.	Zip Code		10	g. Citizen of What C	ountry?	
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215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	uneral		dent Ever in U.S. ces?				? (Specify Yes or No- uerto Rican, etc.)	14. Race - An White, etc	nerican Indian, Black,	
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2121 ould be fill Mental I marked	Be	Morris H.		aham			Annie		ell	
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7 - 2 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5		1 Burial 2 Tremation 3 Removal from	n State crema	atory or other pl	ace)	1			-	
Baltimore, permit Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Gr	eenmou		s of Facility	8-6-07		re, Md.	
Ba perm Depa Impo injur		A la des la Carres					Ave., Ba	F.H. Eas	Md. 21202	
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		23b. Was decedent pregnant in the past 12 months?	h	2 Fetal de	eath 3	Ectopic p	regnancy	Month	Day Year	
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To the Hospital within 24 hours To the Funeral completely filled	edical C	29a. Certifier 1 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis of	examination and/or	eath occurred a	t the time, on my opinio	date and place	e, and due to the cause irred at the time, date a	e(s) and manner as a	stated. o the cause(s)	
To with	Me	and manner sta 29b. Signature and title of certifier	ted.		29c. Licen	se number		29d. Date signed ((Month, Day, Year)	
		(wide Ha D)	111		0.C	.M.E.		August 1, 200	7	
		30. Name and address of person who completed cause								
V	tate	Carol Allan, MD Assistant Medical E 31. Date filed (Month Day, Year)	xaminer 111	Penn Stre	et, Baltim	nore, MD 2	21201 			
Regis		31. Date filed (Month, Day, Year) AUG 0 3 2007	as S. A	gover.						
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			For State Registrar	State of Maryl		artment of H <i>tificate of L</i>			giene Reg. No. 2	U7	2 + 89 :	
	Physicia	an	1. Decedent's Name (First, Middle, La	•	Jones			2. Date of Dea	_	2007	3. Time of Death	
	/Medic	al	Stella Maa. Facility Name (If not institution, given	argaret	Jones	4b. City. Town, or	Location of Death	August	4c. County		11:49 AM	
	Examin	er	1730 Pleasentville Drive Glen Burnie Anne A									
	Funeral Director		045-20-4843	Sex 7. Age (In 1 □ M 2 💢 F	yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Jan. 3	1 1926	9. Birthp Coun	place (State or Foreign httry) PA	
	yland Iow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside City Limits	
	e Mar 3a-f sh tiffed	Director	Maryland Anne A	rundel		Gle	n Burnie				1 ☐ Yes 2 X No	
	with that a or 21	Dire	10e. Street and Number 1730 Pleasentvi	lle Drive		10f. Zip Code	21061		10g. Citizen of	What Cour	ntry?	
	death ms 23 must	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. \	e - Americ						
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☒ No	Specify:	Hican, etc.)	Specif	etc. nite		
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yla	nould to d Ment narked natic e	2	<u> </u>	sage	405 14-115		Anna	Varg				
Mai	nd 2 sh ulth and 27 Is n r traun		19a, Informant's Name/Relationship Susan Pyle (daughter)	I	ng Address <i>(Street a</i> Pipers P					Code)	
ore,	of Hea		20a. Method of Disposition	20	0b. Place of Dispo	sition (Name of natory or other place	ery Augus	Date			or Town, State	
ii Ei	Page tment tant: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	e, Ma	aryland							
Bali	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	Malle	nol):	2. Name and Address 3111 Moun	tain Road	tallings d, Pasac	lena. MD	1 Hom 2112	ne, P.A. 22	
			23a. P. nt. Enter the disea , or co- shock, or heart failure. List on Immediate Cause (Final	one caus on each line.	death not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
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	the de	nysic	1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time 9□Unknown								
Division or Vital Records, P.O	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a		Part II. Other significant conditions		t resulting in the u		en in Part I.	23e. Did to			ne cause of death?	
eco	law rec as bee 2 shou	Completed by				0		24a. Was	an 24b.	Were auto	psy findings available mpletion of cause of	
<u>=</u>	sician: The lav certificate has rector, page 2	Com						perfo 1☐ Yes	rmed?	death? 1 ☐ Yes		
Vit	sician s certifi irector) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatien	t 3 DOA Othe	26. Place of Deat	th <i>(Check only o</i> ome 5 A Resid		/0		
n or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	on: To	27. Manner Death 1 Chatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injur Work	y at k?		now injury occur		<u>y) </u>	
risio	Attend death.	Certification:	2 Accident investigation 3 Suicide 6 Could not to	e 28e. Place of injury -	At home, farm, str		Yes 2 □ No	28f. Location (S	Street and Num	ber or Rura	al Route Number,	
Ŏ	A be see a second and a secon											
28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and City or Town, State) 28g. Could not be determined 28g. Place of injury - At home, farm, street, factory, office 28g. Could not be determined 28g. Place of injury - At home, farm, street, factory, office 28g. Could not be determined 28g. Place of injury - At home, farm, street, factory, office 28g. Could not be determined 28g. Place of injury - At home, farm, street, factory, office 28g. Could not be determined 28g. Place of injury - At home, farm, street, factory, office 28g. Could not be determined 28g. Could not be determined 28g. Place of injury - At home, farm, street, factory, office 28g. Could not be determined 28g. Could not be determine												
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signe	ed (Month,	Day, Year)	
) elignee M	Altendrup	Doctor	02	1684		08	3/00	2/2007	
	2		29b. Signature and title of certifier When the second side of certifier 30. Name and address of person who are second side of certifier 31. Date filed (Month, Day, Year)	completed cause of death HIR AWY	(Item 23a) (Type,	Print) DR.	C.V.C	TRIA	e-M.0	-	/	
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	ranks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State Registrar	State of Mai		rtificate of	Death		g. No.	4374			
	Physici	an	1. Decedent's Name (First, Middle, Last) Sheila Anne Kov					Date of Death Month	Day Ye ar	3. Time of Death			
	/Medic	cal	4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death	1 2007 4c. County of Death					
	LAdiiii	iei	Suburban Hospita	1		Bethesd		Montgome	ry				
	Funeral Director		5. Social Security Number 218-56-6981 6. Sex 1 Usual Residence of Decedent	7. Age M 2 XF 55	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec 4 1	9. Birth Co. (951 MD	place (State or Foreign intry)			
	yland now at			10d. Inside City Limits									
	e Mar Ba-f sh btifled	ctor	MD Carroll		Sykesvil	,				1 ☐ Yes 2 📉 No			
	ath with th 23a or 20 ust be no	Funeral Director	10e. Street and Number 4465 Bartholow Roa			10f. Zip Code 21784	_		USA	Citizen of What Country? USA			
9036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 🌠 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:)	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:		14. Race - Amer Black, White Specify: wh	ite			
15-(in 72 h 1 "natu Iedical	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of workir d)	ng 1	6b. Kind of Business/I	ndustry			
212	filed withi Hygiene. vther than	Som C	Elementary/Secondary (0-12)	College (1-4or 5+)			office spe		defense				
Maryland 21215-0036	should be filed and Mental Hygical marked other matic event, the	To Be (17. Father's Name (First, Middle, Last) Vernon Jett				18. Mother's Name LaRue Irv	, ,	aiden Surname)				
/lan	2 should and Men Is marke raumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2										
e,	s 1 and 2 should of Health and Mer Item 27 Is marke other traumatic		Mr. Robert Koval (s	spouse)	20b. Place of Dispo cemetery, cre				Oc. Location - City or	Town, State			
Baltimore,	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Ebenezer	UMC Ceme	tery 8-6-0	٠. ا	ykesville,	•			
Bal	permit. Page Department Important: II any injury or once.	ta 7	21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784										
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. breast caucer Due to (or as a consequence of):										
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					 -			
	execute r and al-trans	Examiner	that initiated events resulting in death) Last		consequence of):								
68760,	rificate be executed g physician and as the burial-transit	ledical I		l									
.O. Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	sician/N	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ives birth 2 □ Fetal death 1 □ Ives 2 ☑ No 23d. Date of death 2 □ Fetal death 2 □ Other (specify) □										
rds, P.	w requires that been signed b should be deta	ed by Phy	Part II. Other significant conditions con	- 4		nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death? obably 4 □Unknown			
Division or Vital Records,		Completed						24a. Was an autopsy perform 1 Yes 2	prior to c	topsy findings available ompletion of cause of 2 ☐ No			
Zit.	Physician: this certificral director,	o Be	25. Was case referred to medical examiner?	lospital:	t 2 ☐ ER/Outpatier	nt 3 DOA Oth	26. Place of Death) nce 6 □Other (Spec	iful			
n 0	ding Phy J. After thi funeral c		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	28b. Time o		ry at 2	28d. Describe how		<i>ay)</i>			
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	Hospital	Medical Co	29a. Certifier (Check only one) 1 Certifying Phys	now On the basis of a	vamination and/or in	vectigation in my	oninion doath occurr	ad at the time de	use(s) and manner as te and place, and due	to the course(s)			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and market state		29c. Licens	se number	29	d. Date signed (Month	, Day, Year)			
	1		1 Jones -	- 22/25	- MD		743083	3	August	01,2007			
1	0		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type,	Print) euter [Drive # 30	O Roch	ville MD	Day, Year) 01, 2007			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 3	2007 Registrar	's Signature	Sparke							

Koval, Sheila 8/1/07 1144 Am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month W:25M Margaret Madeline Karczmarek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore OSCICIO 6 Inder 1 Year | If Under 2 nths | Days | Hours | FrankLin 59 yare Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Min. 83 215-18-3806 Maryland Director Apr 26, 1924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2X No Md Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5135 King Avenue U.S.A. 21237 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Cosmetologist Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be Robert Everett Harr Margaret Schouck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margorie Barilone (daughter) 5125 King Ave. Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Pages permit. Pages 1 Department of H Important: If ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem 8-7-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Şervice Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, FA budo 1201 Dundalk Ave. Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner neart congestive Sequentially list conditions, Due to (u. s a consequence of) in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-transi Exam Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No ad hesions 24a. Was an certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 TYes 2 ER/Outpatient 3 DOA 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of ne Hospital or Attending Pin 24 hours after death. 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore, MD 21237 9000 Franklin

DHMH 17 Rev 1/2001

Registrar

Yodit

31. Date filed (Month, Day,

N2guss

3

AUG 0

32. Registra s Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician Bonita В. Luedtke /Medical 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice Timonium 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🛣 Director 579-52-7400 Usual Residence of Decedent 10h County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Inaportant; If item 27 is marked other than "rafural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at Director

Month 7:50 p 2007 Aug. 4c. County of Death 4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Nov 26, 1939 Washington, D.C. 10d. Inside City Limits 1 ☐ Yes 2 No MDBaltimore Catonsville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1319 Lincolnwood Drive 21228 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 X Married white 1□ Yes 2ENo Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Lester Burge Louise Thompson

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Mem. Park

2. Date of Death

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1319 Lincolnwood Drive, Catonsville, Md. 21228

8/6/07

Date

22. Name and Address of Facility Sterling Ashton Schwab Witzke F.H. of Catonsville, Inc. 21228 Edmondson Ave.,

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

Rockville, Md.

3. Time of Death

Funeral

2

Completed

Be

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

20a, Method of Disposition

Charles W. Luedtke, husband

1 N Burial 2 ☐ Cremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

7:50 p.m.

AUG. 1, 2007

Examiner Be Completed by Physician/Medical

Certification: To

Medical

DR. EDDIE NAKHUDA

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans Division or Vital Records, P.O. Box 68760, Attending Physician: Hospital or

BONITA LUEDIKE

State Registrar

shock, or heart failure. List onl	lly one cause on each line.	Interval Between Onset and Death									
Immediate Cause (Final disease or condition resulting in death)	a. NON SMALL CELL LUNG CANCER	Oriset and Beauti									
()	Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b										
Cause (Disease or Irijury that intiated events resulting in death) Last	c										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Month											
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1										
	24a. Was an autopsy prior to co	opsy findings available									
	performed? death? 1	2 □ No									
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Speci	ify) HOSPICE									
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation											
3□ Suicide 6 □ Could not 4 □ Homicide determine		al Route Number,									
29a. Certifier 1 X Certifying	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as	stated.									

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

			For State	State o	of Marylar	-	artment of H <i>rtificate of L</i>		•		4	94,895
			Registrar 1. Decedent's Name (First, Middle)	e, Last)			lineate of t	Jeaui	2. Date of De	Reg. No.	4.2	3. Time of Death
	Physicia		Louise	Elise			Long		Month	30, 200	Year	М.
No.	/Medic Examin		4a. Facility Name (If not institution		ımber)			r Location of Death			y of Death	11:15AM
			14997 Health (Center Dri	i <u>ve</u>	_		Bowie		Prin	ce Ge	eorge's
7	Funeral		5. Social Security Number 578-01-3484	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birthp	place (State or Foreign
A.c.	Director		Usual Residence of Decedent	() III	101	Yrs.			June 1	5,1906	Wash	ington, DC
	/land low at		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				1	10d. Inside City Limits
	Mary a-f sh ified	ş	Maryland Prince	George's	3		Bowie					1 ☐Yes 2x No
	th the or 28,	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at		14997 Health				20716				U.S	
	er de litems	Funeral	11. Marital Status	Armed Fo	cedent Ever in U	I.S. 13. \	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ce - Americ	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ried 1 ∏Yes If Yes, Gi Year or D	146		1 □ Yes 2 / T <u>x</u> No	Specify:		Specia	y Whi	te
9	2 houra	led	15. Deceden	t's Education		16a. Decer	dent's Usual Occupa	ation		16b. Kind of B	Rusiness/In	ndustry
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2	ygien ygien er th t, the	Con	8th			Post	ing Clerk			Hardwa	are S	tore
Maryland 21215-0036	be filk d oth	Be	17. Father's Name (First, Middle,	,	- 11			18. Mother's Name			,	
<u>ya</u>	1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	은	Gottfried		Frankha			_	la1ena	Hanr		
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	ss 1 and of Health Item 27 other tr		Barbara Mason 20a. Method of Disposition	(Daughte	20b. F	Place of Dispo:	Eastern Station (Name of	1 [Date	le, Mary	land	21666
OL.	Pages nent of int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	cemetery, cren	matory or other place	e) Augu	ıst 2,		,	,
altimore,	permit. Pages Department of i Important: If its any injury or o once.		21. Signature of Funeral Service		1 1 0	rt Line	coln Ceme. Name and Addres		007 Se Funer	Brentwo al Home	od, l	Maryland
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	Physician		Immediate Cause (Final disease or condition			t Fail						Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq							
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	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	uence or						
-	execution and ial-tra	Exar	that initiated events resulting in death) Last	c Due to	(or as a conseq	uence of):						
8760,	icate be executed physician and s the burial-transit	dical		d								
9		Medi										
ROX	w requires that the death certify been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna		Ectopic pregnancy				ate of delive	,
	e dear	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No		nant at time of d		Other (specify)			Mo	onth	Day Year
7	hat the		9 ☐ Unknown Part II. Other significant condition			ulting in the ur	adortuina aquea aiva	n Dort I	220 Didte		t-throto to th	Coltage of Acade 2
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	sician: Th certificate rector, pag		25. Was case referred to medical					CC. Blace of Dooth	1□ Yes	2 No		2 No
>	Physician: this certific ral director,	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatient	t 3 DOA Othe	26. Place of Death er: 4 □ Nursing Hor			(Engelf	y) Assisted Livy
ō	ng Phys ter this neral dii		27. Manner of Death	28a. Date		28b. Time of Injury		at		now injury occur		y) · I)
SION	endin ath. or: Af he fur	atio	1 Natural 5 Pending	ation	III, Day 1 Ca.,	ingu. y		Yes 2 □ No				
Š	or Att	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inod 26e. Place	e of injury - At ho ing, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office	2	28f. Location (S City or Tow	Street and Numb	per or Rura	al Route Number,
2	pital ours al		29a. Certifier 1 Certifyin	- Shusialan: To the	the at of my kno	- de dooth	The state of the s					
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)	g Physician: To the Examiner: On the band man	e best of my kno pasis of examina Iner stated.	wiedge, deam ition and/or inv	estigation, in my op	e, date and place, a pinion, death occurr	and due to the or red at the time,	cause(s) and ma date and place,	anner as si and due to	tated. o the cause(s)
	o the vithin of the comple	Mec	·				29c. License	number		29d. Date signe	d (Month,	Day, Year)
	Y		· ///	MD			DS	:0343		Tuly	50,	2007
5	2	\vdash	30. Name and address of person	who completed caus	e of death (Item	n 23a) (Type, F	Print)			3049		1 -
X			Kelvin Heo	MD M	999 H	lealtu	Center	Drive 7	4-201	Bowie	Mary 14	nd 60716
	Stat		31. Date filed (Month, Day, Year)	32. R	legistrar's Signa	iture	Lack!					Day, Year) 2007 and 70716
	Registra		AUG U	3 4001	Market Park	10. 14	and the same of th					_

		•	1 - State Amend Item	State of I	Maryland / [per dr.,g	Depa	rtment o	f He	ealth a	and M	lental Hyg	iene eg. No.		7	24:1	19)	
	Physicia		1. Decedent's Name (First, Middle, L								2. Date of Dea Month	Day	Yea	r	Time of I		
4	/Medic	al	Richard Veikko 4a. Facility Name (If not institution, gi		er)		4b. City, Tow	vn, or l	ocation o	of Death	June 30	7	2007 8:23 PM 4c. County of Death				
	Examin	er	Cozy Country Co			ŀ	Ba1t	ore				Baltimore					
	Funeral Director				Age (In yrs. last bir 89	thday)_ Yrs.	If Under 1 Y Months Da	ear ays	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Mar 16,	Year) 191	.8 0	irthplace Country) hio	(State or	Foreign	
	pud *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation							10d. li	nside Cit	y Limits	
	f sho	٥	MD Balti	more			imore							1	□Yes	2 No	
	28a-	rect	10e. Street and Number	more		, G. L. C.	10f. Zip Co	de			1	l0g. Citiz	en of What	Country?			
	h with	al D	12820 Eastern Av	enue					21220)			USA				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Mealical Examination traumatic event, the Mealical Examination of the rediffied at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? □No		Vas Decedent Yes, specify ☐ Yes 2 ▼		panic Ori , Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Ar Black, Wi Specify:				
Maryland 21215-0036	rithin 72 hounder.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 achievements and the completed of the complete of							ing	16b. Kind of Business/Industry				unk		
22	Hygier Hygier ther ti	S	12 17. Father's Name (First, Middle, Las	2 st)	m	nach	inist		18. Mothe	r's Name	e (First, Middle,	Maiden S	Sumame)				
auc	id be fental h	To Be	Issac R. Lund						Mai	ry S	. Routsa	ıla					
ary	shoul and M mari umati	-	19a. Informant's Name/Relationship	(Type, Print)	196	. Mailin	g Address (St	reet a	nd Numbe	or Or Rura	al Route Numbe	r, City or	Town, State	, Zip Cod	(e)		
Σ	and 2 salth a n 27 li		Richard Lund/son	1					d Ro		altimore						
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Spec	cify)	310	nry, cřem	natory or other	r place			Date		cation - City				
Balt	permit. Depert import any inj		21. Signature of Funeral Service is Anthony	Mean	sand		Baltim	ore	, MD	21	rd 655 V 201		altimo		tree		
,092	Physician /Medical Examiner	al resulting in death) Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Due to (or as a consequence of):									о гозрігаюту ап	031,		Inte	nval Bety set and t	ween	
Box 68	death certific e ettending p ed for use as i	Physician/Medic								ictopic pregnancy Other (specify)					23d. Date of delivery Month Day Year		
ds, P.O.	8 G 9	by	Part II. Other significant conditions	contributing to dea	th but not resulting i	in the ur	nderlying caus	se give	n in Part I			bacco us	se contribute	e to the ca			
of Vital Records,	The ete h page	Completed											death	to comple	tion of c	available ause of	
/ita	⊆ ≝ ö	Be	25. Was case reterred to medical examiner?	Hospital:				Othe	-	•	h (Check only o						
of	99 =	-T	1 ☐ Yes 25 No 27. Manner of Death	1 Inp		utpatien			4 🗆 NI	ursing Ho	28d. Describe h		Other (S	Specify)			
O	ding h. After fune	ton	1 Natural 5 Pending 2 Accident investigat	28a. Date of (Month,	Day Year)	Injury	м	Injury Work	? ∕es 2 🗆	No							
Division	al or Attending Phy s after death. if Director: After this od in by the funeral of	Certification:	3 Suicide 6 Could not determine	286. Flace 0							28f. Location (Street and Number or Rural Route Num City or Town, State)				ute Num	ber,	
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	Medical C	29a. Certifier TV Certifying (Check only 2 Medical Ex	Physician: To the bas aminer: On the bas and manne	is of examination as	ge, death nd/or inv	n occurred at t	the tim	e, date ar sinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner place, and	r as stated due to the	i. cause(s	:)	
)	To the within To the comp	M	29b. Signature and title of certifier	ce)	Emilye	h	1		number 049	01		29d. Date	e signed (M	onth, Day	Year)		
				mounity (Physician	17	Print)	Dev	dalk	c Aug	e Dun	del	k M))2/2	99		
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 3 2	2007 32/Re	gistrar's Signature	Son	WELL .						_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year 11:24 PM MCCLELLAN 29 200 F ひんし 4c. County of Death 4b. City, Town, or Location of Death Citu Baltimore Baltimore If Under 1 Year | If Under 24 Hre 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6 Sex Months Days Hours 1 → M 2 □ F 79 6/23/1928 MARYLAND

10d. Inside City Limits

BLACK

USA

Specify

14 Race - American Indian.

CONSTRUCTION

Black, White, etc.

XXYes 2 □ No

MD

Approximate Interval Between Onset and Death

2067

29

ulu

Battimore

2 days

Physician RAYMOND /Medical 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hispital 5. Social Security Number **Funeral** 216-20-3574 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County r 28a-f show notified at 10a. State BALTIMORE CITY N/A MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with r than "natural", or items 23a or the Medical Examiner must be a 21230 1141 W. CROSS STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? TV Yes 2 No US If Yes, Give ARM 11 Marital Status 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Year or Dates:1 945-48 1 ☐ Yes 2 ☑ No Specify ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LABORER 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) and 2 should be DAISEY BROWN EDWARD MCCLELLAN -aymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important: If Item 27 is any injury or other trau WIFE 1141 W. CROSS STREET, BALTIMORE, MD 21230 BRENDA MCCLELLAN 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition Pages Moration 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEM . GARRISON FOREST
22. Name and Address of F OWINGS MILLS, 8/06/07 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS FUNERAL HOME 21207 AVE, BALTIMORE, MD ner the distase, or complications that caused the death, or heart foure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest Immedi le C. use (Final disease ondition resulting in death) Shock ptic Physician /Medical Due to (or as a c insequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of) Box 68760. pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed Month

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32. Registrar's Signature

attending physician for use as the buria ed by the a detached f signed by the has page 2 certificate or Attending Physician: this funeral After death. the within 24 hours after death To the Funeral Director: filled in by

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Completed

Certification: To Be

Medical

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Division or Vital Records,

Hospital

To the

23d Date of delivery Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐Unknown 1 🗌 Yes Mellitus Dialactes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Liscase Vascular autopsy performed? 1 Yes 2 □ Stage 2 ∏ No End scase 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Mann r of Death 28a. Date of Injury (Month, Day Year) 28d Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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Hospita

State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3.-Time of Death ecedent's Name (First, Middle, Last) Year Month Day 7:43 PM 31 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memoria Date of Birth (Month, Day, Yea: 4 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ecurity Number Year) 1 □ M 2 🗷 F Months Davs Hours Min Usual Residence of Decedent 10c. City, Town or Location 10h. County 10a State 10d. Inside City Limits 1XYes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BORD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes → No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other) Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer lung disease or condition resulting in death) a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1□ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

and

attending physician

After

within 24 hours after death To the Funeral Director:

To the Hospital

Physician

Examiner

Funeral

Director

28a-f show

death v

Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the <u>Medical Examiner must be notified at</u>

/Medical

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Be Completed Certification: To

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗹 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Mor.

Medical

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

30. Name and address

29b. Signature and title of certif

5 Pending investigation

6 ☐ Could not be determined

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

would

Injury

Date of Injury (Month, Day Year)

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 31, Day 2007 Year 2:15 P M Joseph Moorhouse 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 29, 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min 1919 87 149 09 7398 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 1 ☐ Yes X☐ No Fort Washington Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20744 718 Calvert Lane, 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛱 🏋 🕅 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Supervisor Supply Warehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Essi Zinn Joseph Moorhouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11304 Old Fort Road, Fort Washington, MD 20744 Gail Moorhouse (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee Crematory Aug 2, 2007 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Se Alexandria Ferry Road, Clinton, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

Certification: To Be

Medical

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

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Department of H
Important: If ite
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within 72 hours after

2 should be f and Mental

Baltimore, Maryland 21215-0036

Director

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attending physician and for use as the burial-transit The law requires that the death certificate be executed ed by the a signed by t I be detach certificate has be rector, page 2 s

this

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: ours after death.
neral Director: After this filled in by the funeral d within 24 hours a

To the Funeral C

completely filled To the

25. Was case referred to medic examiner?	100
1 ☐ Yes 2 No	

5 Pending

27. Manner of Death 1 Natural
2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

nedical		
	Но	ospital: 1 X Inpatien
Pending investigation	1	28a. Date of Injury (Month, Day

	ПО	spitai.	1 X Inpatient	2	ER/Outpatient	3□[AOC	
Pending investigation	n		Date of Injury (Month, Day Yo	ear)	28b. Time of Injury	М	28c.	Inju Wo
Could not be determined		28e.	Place of injury building, etc. (- At he	ome, farm, stree	et, facto	ory, o	ffice

ent 2□	ER/Outpatient	3□□
ury uy Year)	28b. Time of Injury	

			-0
ent	3 🗆 🛭	AOC	Other: 4
of		28c.	Injury at Work?
	M	1	1 □ Yes 2

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAHram Redjaee 4467 of PBranch Ave #201 Temple Hills MD
20748

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MACEL 4:30 200 MICHAE NUL "/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltinere Mercy Nedeccul 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 XM 2 ☐ F Yrs. Mar 16, 1959 Maryland 218**-**78-5852 48 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director Sparrows Point Md. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21219-2380 U.S.A. 4707 Greencove Circle 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Self-Employed yr Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Nancy C. Rush Edward John Macek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21219 Connie H. Macek (wife) 4707 Greencove Circle Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State 8-3-2007 Timonium, Maryland Dulaney Valley 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 21222 Approximate Interval Between Onset and Death 2 Week 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** Caucer /Medical Due to (or as a consequence of) jocardial infarction 24 hours Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 1 Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the i 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 0

30. Name

address of person who completed cause of death (Item 23a) (Type, Print)

ST. PAUL

32. Registrar's Signature

ST.

301

29c. License number

DS6299

21202

29d. Date signed (Month, Day, Year)

100°

State

Registrar

Registrar's Signature

The section

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTPM#25 perPHYS G870 8/3/07 WS
State of Maryland P Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 10:00 AM helma /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Copper Ridge Svkesville Carroll If Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Jan 28, 1915 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days Months Hours Country) 1 □ M 2 🔽 F Yrs. 92 Jan 235-03-5897 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2√ No Funeral Director Sykesville MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 710 Obrecht Road E34 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? "natural", or items 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White þ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Cleveland Walker Elsie Mae White ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20871 19a. Informant's Name/Relationship (Type. Print) Mrs. Dolores Peters Davis (Daughter) Health a 23700 Grapevine Ridge Terr., Clarksburg, MD item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of important: If it any Injury or o once. 1 N Burial 2 □ Cremation 3 Removal from State Wallace Memorial Gardens 7/27/2007 Clintonville. WV 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License HAIGHT FUNERAL HOME & CHAPEL, PA (Bo Sykesville, MD 21784 (410)-795-1400 MO0X64 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 120121 10845 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation thours after death.

-uneral Director: Afely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 00059943 23,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 lann c. Aselmo 307

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ROCTOR **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner BALTIMA TOWSON GILCHE157 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex Year) **Funeral** Min. Months Davs Hours 1 □ M 2 💢 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MARSH MD WHITE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 21162 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HO. Co. PUBLIC SCHOOL filed within Hygiene. n and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TERESA PROCTOR, SR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/162 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s rtment of Health ar LARRY KNOTTS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State FARK BALTO, MD 4 □ Donation 5 □ Other (Specify) GARY L. KAUFMAN FUNERAL HEME AT MAP, INC. 7250 WASHINGTON BLVD EXCLUDED MIN DELECTION 21. Sign ture Funeral Service Licensee Nan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EXRS DEMENTIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical for use as the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 No 3□ DOA Medical Certification: To 1 ☐ Yes After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 6565 NCHARLES ST, SUITE 216, TOWSON, MO 21204 DANIEUE DOBERMAN, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year AUG 0 3 2007 State Registrar

Suzanne Melanie P		lips St	ate of I	Maryla	nd / D		tment c			Men	tal Hy	giene	D N	21		7 21.00
Physician/		egistrar . Decedent's Name (First, Midd	e,Last)								2	2. Date of I				3. Time of Death
Medical Examiner		Suzanne Melani		11ips	3							July 30	, 2007	y Year		0711 hrs
C-	4	a. Facility Name (if not institution	n, give stre	eet and num	nber)				, Town, or L	ocation o	of Death			4c. County of Baltimore		.t.,
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Funeral	5	. Social Security Number	6. Sex	ł	7. Age (Ir		st birthday)	_	nder 1 Year oths Days	+		,	•		Foreign	washington,
Director	<u> </u>	212-19-2878	1M	2 <u>X</u> F		35_	Yı	s.				March	27,	1972	Cou	ntry) D.C.
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5-0036 led within 7 Hygiene. other than th. Medic.	1	7. Father's Name (First, Middle	, Last)			1								ien Surname)		<u> </u>
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MD and 2 shouth and m 27 is aumati	- II	Percival A. Ph	illip	s / I	Fathe		16000				[Date	20	wn, MD		
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/Medical	Į	failure. List only one caus-	on each I	_{ine.} Cardiac						- "						Between Onset and Death
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Division o Hospital or Attending 24 hours after death, Fameral Director: After fely filled in by the fune	5 -	4 Homicide	ermined	(Specify)												
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To the He within 24 To the Fi completel	<u> </u>	29b. Signature and title of certi	an	d manner s	stated.	-			29c. Licens							nth, Day, Year)
	=	255. Signature and title or certi)	10	01) ~			O.C.					July 30, 20		
	-	30. Name and address of person	In who com	inleted carr	ise of des	ath (Item	(23a)							_		
Ø				Medical			111 Pen	Stree	et, Baltim	ore, M	D 2120	1				
Stat	te	31. Date filed (Month, Day, Yea	9 000	32. 7	gistrar's	Signatu	ire .	Stad	()							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:15 PM 2007 July 29. Roland Richard Ouinn Sr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center @ GBMC Baltimore Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Months Days Hours Min. 1 X M 2 □ F 74 May 11, 1933 Director 011-24-1961 Massachusetts Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Cecil Rising Sun 10g. Citizen of What Country? 10e. Street and Number 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be i 615 Connelly Road 21911 USA Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I ☑ Yes 2 ☐ No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No altimore, Maryland 21215-0036 Specify ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fire Department 5+ Lieutenant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h 1 and 2 should be 2 Aldege Joseph Ouinn Blanche Anita Descheneau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 615 Connelly Road, Rising Sun, Maryland 21911 Thelma N. Quinn / Wife Department of Heal Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp 8-3-07 Towson, Maryland 21. Signature of Funeral Service License McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) T-CELL NON-HODGKINS MONTHS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown DIABETES 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 ther (Specify HOSPICE Hospital: 200 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No I hours after death.

uneral Director: A 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide A 24 hours the Funeral Directory filled in Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 064395

State Registrar 31. Date filed (Month, Day, Year)

DOBERMAN, MD 6565 N CHARLES ST, 8VITE 216 TOWSON, MB 21204
(Year) 92. Registrar's Signature

AUG 0 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		•	For State Registrar	State of Maryland / D	Department of Certificate o		nental Hygie. Reg.	6.0-1	24905
	Physici		1. Decedent's Name (First, Middle, Last)	ELIZABETH	REDI	MOND	2. Date of Death Month AUGU ST	Day Year 01 2007	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town	n, or Location of Death		4c. County of Death	
-	Funeral		5. Social Security Number 6. Sec				1 0 Date of Blab	9. Birth	place (State or Foreign
Ŀ	Director		Usual Residence of Decedent	IM 278 7 7	Yrs.	y3 110013 11111.	8. Date of Birth Month, Day, Yo	129	" ITIV
	Aaryland Show	or	10a. State 10b. County	10c. City, Town	h or Location				10d. Inside City Limits 1 Yes 2 □ No
	or 28a-1	Director	10e. Street and Number	F . 0 1	10f. Zip Cod	9 10 - 1)	10g.	Citizen of What Cou	intry?
	death w	Funeral	2402 Hollins	12. Was Decedent Ever in U.S.	13. Was Decedent	of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	
36	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examilian mast be rediffed at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢	Cuban, Mexican, Puerto No <i>Specify:</i>	nican, etc.)	Specify: Specify:	ack
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	filed within Hygiene. wher then "	Сотр	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurses	Hosis-		Hospi-	Fall
Maryland	should be filed nd Mental Hygi marked other imatic event, I	To Be	17. Father's Name (First, Middle, Last)	Dowell			ne (First, Middle, Mail	tt.	
Mary	S S S		19a, Informant's Name/Relationship (Ty	Daughter) 2	1.0 11.11	eet and Number or Ru.	Pal Route Number, Co	ity or Town, State, Zi	ip Code) D 21330
ore,	97		20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b. Place of cerneter	Disposition (Name of ry, crematory of other			. Location - City or T	Town, State
Baltimore,	permit. Page Department of Importent: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligens	Loud		these of Facility Gr			rvices
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	Physician		shock, or hear value. List only of Immediate Cause (Final disease or condition resulting in death)	Chronicobs	structive	2 Pulmon	ary Dis	ease	Onset and Death ≈ 30 yr
	/Medical Examiner			Due to (or as a consequence	of): arteri	1 Disec	use		x 54rs
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):				
60,	ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as a consequence	of):		-		
(09289	ntificate ing phys a as the	Medical	IF FEMALE:	J	-				
P.O. Box	The law requires that the death certificate has been signed by the attending plagge 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregna 5 □ Other (specify			23d. Date of deli-	very Day Year
	ires that signed by d be deta	þ	Part II. Other significant conditions co	ntributing to death but not resulting in	n the underlying cause	given in Part I.		co use contribute to	the cause of death?
Records,	e law require has been si je 2 should b	Completed					24a. Was an autopsy	prior to c	topsy findings available completion of cause of
Vital R	icien: The l certificate ha rector, page	е Соп	25. Was case referred to medical			26. Place of Dea	performed 1 Yes 2 🔀		2 No
of Vi	Physicien: r this certificatal director,	To B	examiner? 1 ☐ Yes 2 万No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Ou	Itpatient 3 DOA	Other: 4 Nursing H	ome 5 Residenc		eify)
ion	ding Afte fune	atlon:	27. Manner of Death 1 ↑ Natural 5 Pending 2 Accident investigation			njury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
Division	i or Attencater death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fabuilding, etc. (Specify)	arm, street, factory, offi	ice	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director:	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	e, death occurred at the	e time, date and place ny opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me			29c. Lic	cense number	29d.	Date signed (Month	2007
/	. 4		29b. Signature and title of certifier Hanath 30. Name and address of person who co DR. Mcumatha Product 31. Date filed (Month, Day, Year) AUG 0 3 20	ompleted cause of death (Item 23a)	(Type, Print)	Clast	30 Himar	o Musuh	nd 21225
	0.		DR. Manatha Prot	hakan 3001, 5 H	Sheets	Street; [المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة المراجعة الم	(
	Sta Regist	ne : rar	AUG 0 3 20	II president to	7				

State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar	,	Cei	rtificate of	Death	,	Reg. No.	247.57	1.07
F	Div. 1.1		1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		Mattie Mae	Coleman		Ranki	n	July	24	2007	
1	Examin		4a. Facility Name (If not institution, give s				r Location of Death		4c. (County of Death	
	· · · · · · · · · · · · · · · · · · ·		Future Care Nur		-		ndallst			Baltin	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	ay, Year)	9. Birth Cou	place (State or Foreign ntry) NC
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Lo	ncation					10d. Inside City Limits
	aryla shov dat	_			Balti						X □Yes 2 □ No
	he M 8a-f otlfie	ecto	MD NA		Daici				10a Citiz	zen of What Cou	ntn/2
	vith th	吉	10e. Street and Number			10f. Zip Code	215		Tog. Oniz	U.S.A.	
	s 23s	era	5712 Jonquil Av	C 12. Was Decedent Ever in U.	c 13			pecify Ves or No	0- 1	14. Race - Ameri	
	item item	Funeral Director	11. Iviaitiai Status	Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	Rican, etc.)		Black, White	
8	ırs afi Ii'', or xami	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give X Year or Dates:		1 ☐ Yes 2√√ No	Specify:			Specify: B3	.ack
5-0036	within 72 hours after death with the Maryland jiene. r than "natural", or ttems 23a or 28a-f show the Medical Examiner must be notified at	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation	kina	16b. Kir	nd of Business/II	ndustry
212	hin 7 e. an "n Medl	Completed	(Specify only highest grade	College (1-4or 5+)	life.	DO NOT use retire	d)	Mig			
	filed within Hygiene. Ither than "	9	12th grade	na		Housewi	r		L	Home	
2	be file ital Hy id oth event	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam			Surname)	
<u>X</u>	Mer Mer arke	ပ္	John Coleman		T		Mattie				
Maryland 2	C1 (0 - 0) (2)		19a. Informant's Name/Relationship (Type			ng Address <i>(Street</i> ? Jonqui					21215
	s 1 and strength the strength other tr		Theodore Rankin 20a. Method of Disposition					Date		cation - City or T	
وّ			1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		osition (Name of matory or other place	1	107			
Baitimore,	it. Pg intme intant injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licent	10.1		llawn 2. Name and Addre	7/30	707	вати	cimore	Co, Md
g	permit. Page Department of Important: If any injury or once,		Mayar	Haham	l N	March F/	H West	Pal+	imo	ro. Md	21215
6			23a. Part1. Enter the disease, or compli	cations that caused the death						Ley Mu	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final			E HEAD	2T -1:	·			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence)	uence of):	C HEM	ET FAIL	LUPAL			
	Examiner										
ļ.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):						
>	cutec nd ransi	Examiner	that initiated events								
Š,	e exe		resulting in death) Last	Due to (or as a consequent	uence of):						
68760,	rtificate be executed ng physician and as the burial-transit	Medical		1							
	E 50 6		IF FEMALE:	3c. If yes, outcome pf pregna	ancv					12d Data of deli	ton.
ô	eath ce attendir for use	ian	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	□Ectopic pregnanc □Other (specify) _	"y			23d. Date of deli Month	Day Year
J.	the d	Physician/	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9□Unknown							
	The law requires that the death ce Ite has been signed by the attendi hage 2 should be detached for use		Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
<u>5</u>	quires n sign	d by						1 🗆	Yes 2[□ No 3 □ Pro	bably 4 hknown
Vital Records,	aw rei	Completed						24a. Was		24b. Were au	topsy findings available ompletion of cause of
ř	The law	mo						perf 1□ Yes	opsy formed? 2 No	death? 1 ☐ Yes	
<u> </u>	siclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
<u>o</u>	hysic his ce I dire	To	1 ☐ Yes 2 ☐ ₩6	lospital: 1 Inpatient 2			4 Wursing H	T		6 □Other (Spec	ify)
0	ng P		27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe	how injur	y occurred	
<u> </u>	tend leath. tor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At he	ama farm of]Yes 2□No	20f Location	/Stroot as	d Number or Pu	ral Route Number,
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	reet, factory, office			own, State		rar rioute rumber,
	spital		29a. Certifier 1 ertifying Phy	sician: To the best of my kno	wledge, dea	th occurred at the ti	ime, date and place	l e, and due to the	e cause(s)	and manner as	stated.
	ne Ho ne Fu ne Fu	edical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ation and/or i	nvestigation, in my	opinion, death occi	urred at the time	e, date and	d place, and due	to the cause(s)
1	To the vithing To the complex	Me	29b. Signature and title occeptifier			29c. Licens	se number		29d. Dat	te signed (Monti	n, Day, Year)
			1	L	1.P.	55	1722		JUL	-Y 26	2007
	9		30. Name and address of person who co								_
	ر ل		LEUNARD RICHARDS	32 Registrar's Signa		ENE TRE	E ROAD #	300 Pik	ESVIL	ie MD	21208
	Sta Regist		31. Date filed (Month, Day, Year)		4 As	anti)					

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of Mary		artment of F			giene Beg. No.	7 24900
	Discount of		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Ye	3. Time of Death
	Physici /Medio		Mildred		Reynol	ds		7	31 0	7 4:04PM
	Examir	ier	4a. Facility Name (If not institution, give	3.4	. 1	7	r Location of Death		4c. County of D	
					yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	9 Date of Right	Baltin	
	Funeral Director		5. Social Security Number 6. Sec	M 2□X 71	yrs. iasi birinday, Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 2-17	, Year) -1936	Birthplace (State or Foreign Country) Va.
			227–44–4192 Usual Residence of Decedent	7.1				2 11	1930	va.
	how		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
-0	e Ma	cto	Md. NA	4	Ba	altimore				1 X es 2 No
Mildred	hours effer deeth with the Maryland hours effer deeth with the Maryland ture!; or Iteme 23a or 28a-f ehow at Exertiner must be rediffed at	by Funeral Director	10e. Street and Number	Charat		10f. Zip Code			10g. Citizen of What	
\	• 23a	ra	2300 E. Hoffmar	1 Street 12. Was Decedent Ever	ia 11 6 12	21213		ody Vac as No	US A	merican Indian,
	Item de	ņ	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	110.5.	If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		/hite, etc.
7	urs of	by	3 √Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
3 , M ,	72 hours "naturel",	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation during most of works	na	16b. Kind of Busine	ss/Industry
		nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)			-1 1 - 3
00	e filed w Il Hygier other th		11th grade 17. Father's Name (First, Middle, Last)		Te	eachers A	Aide 18. Mother's Name	/Eirst Middle		City Schools
10	y range build be fi Mental H arked ot atto ever	Be		т	Rsther		M		Cook	-
7 2	2 should be and Mental is marked (aumatic ev	၉	Ernest 19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street	and Number or Rura	il Route Numbe	r. City or Town, Stat	e, Zip Code) 21202 altimore, Md.
7 \$	5 4 7 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		Jacquelyn K. Jo		ughter	1631 N.	Patterso	n Park	Ave., B	altimore, Md.
Rattimore	is 1 and 2 if Health item 27 other tre	1	20a. Method of Disposition		Ob. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City	or Town, State
(-35- 5	permit. Peges Depertment of I Important: If it eny injury or o		1 ☐Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	•		Vet. 8-6-	-07	Owings	Mills, Md.
=	permit. Depertrimports ony inju	i i	21. Signature of Funeral Service License	86		2. Name and Addre			F.H. East	
-	80229	1. 1	Dlady	Ware			North Ave			
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	ications that caused the ne cause on each line.	death. Do not en	ter the mode of dyin	ng, such as cardiac d	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	SEOSIS						IDAY
	/Medical Examiner			Due to (or as a co		Virmon	A			irmi
		er	Sequentially list conditions if any, leading to immediate	Due to (or as a co		o(solomor.				[INOV]
1	od uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
1/2	be executed sicien and buriel-transit		resulting in death) Last	Due to (or as a co	nsequence of):					
, 0928	2 2 2	Ical		J						
Roy 68	eath certifica ettending ph for use as th	by Physician/Med	IF FEMALE:	3c. If yes, outcome of pr						
Č	ettenc for us	lan	in the past 12 months	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3[☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date of Month	Day Year
C	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	701 000011 31	_ Other (specify) _				
Ω	es that the death certific igned by the ettending p be deteched for use as	y P	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
Ž	quires	d be	itmans -	Avritana	WS MYC			1 □ Y	'es 2□No 3□	Probably 4 Unknown
O.	law requii es been s 2 should	plet	mannahillan	Avitana	HAGIA			24a. Was autop	an 24b. Were	autopsy findings available to completion of cause of
, å	The lav	Completed						perfor	med? deat	1?
<u>=</u>	icien: Th certificete rector, peg	Be (25. Was case referred to medical examiner?				26. Place of Death			
, ,	hysic this o	ဥ	1 Yes 2 No		2 D 5 Outpatie		er: 4 ☐ Nursing Ho			Specify)
2	ding Physi h. After this o funeral dire	lon	1 Sentural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Wor	rk? Yes 2 □ No	280. Describe n	ow injury occurred	
Division of Vital Becords P.O.	Attending Physicien: The law requires that the death certifical regard. regard. ector: After this certificate has been signed by the ettending phy the funeral director, page 2 should be deteched for use as it	flcat	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, st					r Rural Route Number,
Ş	after Dire d in b	Certification;	4 Homicide	building, etc. (S	pecily)	7,		City or Tow	m, State)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel birector: A completely filled in by the fu	edical C		sician: To the best of my						
-	o the o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
	⊢		Julm	ringo	num	Dr	makea		04/07	12007
)		30. Name and address of person who co	empleted cause of death	(Item 23a) (Type	Print)	00733		6 100	
_	3		TONY MARGH	BET CL	-1.N.G	my STI	WET Su	16308	Brum	fact impaired
	Sta Registr		31. Date filed (Month) (Lay (e.g.)	32. Registrar's S	Signature	S. C. Carlo	,			
	negisti	211			-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month. Day Year **Physician** July Robert E. Repsher 2007 0 /Medical 4a. Facility Name (If not institution, give street and number) unty of D Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) WO 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 182-18-5580 Director April 6,1922 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 719 Maiden Choice Lane BR308 21228 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other tha any hjury or other traumatic event, ins. and once. Foundryman Foundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Louis A. Repsher Mary Ellen Cannon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane BR308; Olive M. Repsher Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Garden 8/3/2007 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Dra Lemmer <u> 1630 Edmondson Avenue: Catonsville</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** isea heimer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physiclan and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 3 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No his certificate has b I director, page 2 sl 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nersing Home 5 Residence 6 Other (Specify) ပ္ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, n 24 hours after with the Funeral Director: After maletely filled in by the funeral properties of the funeral completely

Baltimore, Maryland 21215-0036

the

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DHMH 17 Rev 1/2001

State

Medical

31. Date filed (Month, Day, Registrar

30 Name and address of person

29b. Signature and title

Maic 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

AMEND TIEM/I OF per EH C870, 8/3/07 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:00 A.M Elizabeth Ann Salasnek 8 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Los Angeles 5. Social Security Number 7. Age (In yrs, last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 25F 83 Director 11/21/1923 California 365-34-0836 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Directo Baltimore Lutherville Maryland 10g. Citizen of What Country? United States of America 10f. Zip Code 10e. Street and Number or be r Gandson Grandson Court 21093 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 ☐ Yes XX No Specify: Specify: White δ 3€Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Antique Dealer Antique Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Henry Ludwig Katherine Courtney 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Constance C. Bourke/daughter 13004 Gent road Reisterstown, Maryland 21136 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans funeral
Chapel—Bel Air Date 20c. Location - City or Town, State 20a. Method of Disposition August 2007 3, Department of Important: If it ō 1 ☐ Burial XXCremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final em to lisam dAys Lumana Physician disease or condition resulting in death) /Medical Due 1 (or as a consequence of): Examiner STruc if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Ö 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ξ Records, Ancer 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Jas autopsy performed death? certificate l 2□ No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Afte 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A rilled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto. md 2020/ 6701 32. Registrar's Signature 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 10:00 A.M 31. 2007 July Denise Schneier-Coke /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4800 Yellowwood Ave. #401 Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 ☑ F 55 March 26,1952 Pennsylvania Director 211-44-0650 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1√√Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 4800 Yellowwood Avenue #401 21209 death Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or **** any injury or other traumatic event *****. 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2☐ No Yes, Give 'ear or Dates: 1 Never Married 2 Married 1 ☐ Yes ♣ No þ Specify: White 3 ☐ Widowed
MXDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Youth Counselor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Schneier Jeannine Prince ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 861 North Beachview Drive Jekyll Island GA 31527
of Disposition (Name of Date 20c. Location - City or Town, State David Schneier/brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel- Bel Air 20a, Method of Disposition August 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2007 21. Sign of runeral Service Licensee 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IN FARCT **Physician** Acute ACUTE MYOCHR BIAL /Medical Due to (or as a consequence of) Examiner ystipidemia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of). physician the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 insufficiency 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Disorder identit 24a, Was an page 2 s autopsy performed 2 🕡 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No director, Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 0 3 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WW 6503

within 2. the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

PAVLK

29c. License number

ITEIGHTS

29d. Date signed (Month, Day, Year)

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			For State Registrar	ate of Maryland		artment of H rtificate of I			giene Reg. No. 💎 🐺				
	-		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Lath	1	3. Time of Death		
	Physici /Medio		Starshell		Sta	ange		Month 7	30 200	ear 7	9:p		
E.	Examir		4a. Facility Name (If not institution, give street	and number)		Location of Death		4c. County of Death					
			1912 Cecil Avenue		Baltimore				NA				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthpla Count	ace (State or Foreign		
40	Director		220-12-8517 Usual Residence of Decedent	82	Yrs.			2–19-	-1925		Md.		
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	Mary -f sh	to	Md. NA		Balti	more			1 KgYes 2 □ No				
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?				
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	filed within 72 hours after death with the Maryland Hyglene. wher than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notifled at	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S med Forces?	S. 13. \	Vas Decedent of H	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race -	America White, e			
36	s afte	by Fu	1 Never Married 2 Married 1]Yes 2. No Yes, Give X		I □ Yes 2X No	Specify:	1110411, 0101,	Specify:		_		
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	othe othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surname)				
<u>Jar</u>	uld by Menta rrked	ToE	Hollis	Gilla	ard		Flore	nce	Gain	es			
Maryland	2 sho and f is ma auma		19a. Informant's Name/Relationship (Type. Pr	,	ı		and Number or Run			ate, Zip (Code)		
	and lealth m 27		Vanda Chambers	Daughter			Dr., Ba			1221			
ore	ges 1 t of H If Ite or otl		20a. Method of Disposition 1 □ Burlal 2 □ Cremation 3 □ Remov	al from State	metery, cren	sition (Name of natory or other plac	re)	Date	20c. Location - Ci	ty or Tov	n, State		
Ħ,	t. Pa rtmen rtant:		4 ☐Donation 5 ☐ Other (Specify)	Kin		. Park	8-4	- 07	Randal	lsto:	n, Md.		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show apportant: In Item 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	Con	22	Name and Addres	ss of Facility North Ave	March Baltin	F.H. Eas ore, Md.	t 21	202		
	100		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death, se on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	1	Approximate Interval Between Onset and Death		
	Physician	Immediate Cause (Final disease or condition resulting in death) a. a. a. a. theimer's dements											
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	77.200	****				0		
		-	Sequentially list conditions, b.	Due to (or as a conseque	ence of):								
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Box	leath certifi attending for use as	Physician/M	23b. Was decedent pregnant	res, outcome pf pregnan □Live birth 2 □ Fetal		Ectopic pregnancy			23d. Date		y		
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<u>o</u>	ndlng ath. r: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		t? Yes 2 □ No						
<u> </u>	r Attend er death rector: / by the f	lific	3 Suicide 6 Could not be 4 Homicide determined 28€	. Place of injury - At hon building, etc. (Specify)		et, factory, office		28f. Location (S City or Tow	treet and Number	or Rural	Route Number,		
	ital o irs aft ral Di led in	Certification:					10						
	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certification in the funeral director, completely filled in by the funeral director.		29a. Certifier (Check only 2 Medical Examiner: O	n the basis of examination	ledge, death on and/or inv	occurred at the timestigation, in my or	ne, date and place, pinion, death occur	and due to the o	cause(s) and mann	er as sta	ted. the cause(s)		
	thin 2	Medical	one) are 29b. Signature and title of certifier	d manner stated.		29c. License							
	Z.≱ Z 8	-	255. Signature and those certifier	m		\	5134	0 1	29d. Date signed (i	In-	ay, rear)		
,		-	30. Name and address of person who complete	d cause of death (liter-	22a) /Tu		13137	٦	1/3/	, 0	′		
	2			one Drive	Su) (Type, F	ic 205	Bal	mou	mb 2	2,2	37		
	Sta	te	31. Date filed (Month Day, Year) AUG 0 3 2007	32. Registrar's Signatu	ire /								
	Registra	ar	MUG U 3 ZUUI	West St.	13234								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 9870 8-13-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 31 Physician 200% 6:00gM /Medical 4c County of Death Name (If not institution, give street and number) Cin Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) MAR. 28,1 9. Birthplace (State or Foreign Country) If Under 1 Under **Funeral** Hours Months Days Min. 1 M 2 M Director Usual Residence of Decedent City, Town or Location 10a. State 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.
ant: If item 27 Is marked other than "ratural", or items 23a or 28a-f show ant: If item 27 is marked other than "ratural", or items 23a or 28a-f show ant; If item 21 is marked other than "ratural", or other traumatic event, ithe Medical Examiner must be notified at MORE 1 es 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code # G 1200 . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BIAC Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DORKER 18. Mother's Name (First, Middle, Maiden Su 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other traionce, DANDRA Mg 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) d21. Signature of Funeral Service Licens e Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due as a consequ Examiner Sequentially list conditions, if any, leading to Immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown 1 TYes 24a. Was an autopsy perform Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 s this certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was cas within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 217 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Medical Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 W Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) mined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

DHMH 17 Rev 1/2001

State Registrar

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	Physici /Medic		Decedent's Name (First, Middle, La Mary C		t			2. Date of De Month Aug 1,	Day	Year	3. Time of Death 12:20 A M
	Examin		4a. Facility Name (If not institution, give	e street and number)			Location of Death		4c. Cour	nty of Death	
	Funeral Director	31.	213 40 9093		rs. /ast birthday) Yrs.	Clint If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept 9	th v. Year)	ce Geo ^{9. Birthp} Coun Mary	lace (State or Foreign
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	h with the 23a or 284 st be not	Funeral Director	10e. Street and Number 9600 Wagner Tra	i1		10f. Zip Code 20735			10g. Citizen o	of What Coun ed Sta	
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Hore	Pages 1 and the pages 1 and th		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			esition (Name of matory or other place		Date 007	Valdor		
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COLUS, T.	uires that signed by Id be deta	by P	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause give	en in Part 1.		obacco use co Yes 2 □ No		ne cause of death?
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1	To II To II	Ž	29b. Signature and title of certifier	mani M	.15	29c. License	number 5295		29d. Date sig	ned (Month,	
1	T		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)			9		
		- 17	Satish Jumani, 1	20 Posserario Sig	naturo	k Drive S	Suite 208	, Waldo	rf, MD	20603	
	Sta Registr		AUG 0 3	32. Registrar's Sig	J. J.	parle					

DHMH 17 Rev 1/2001

			For Stete Registrar	State of Maryland	d / Depa		lealth and I	Mental Hy		24915
	Physici /Medio Examin	eal ier	1. Decedent's Name (First, Middle, Last) Louise T. Stout 4a. Facility Name (If not institution, give s Doctors Hospital			Lanha			7, 2007 4c. County ol De Prince	George's
	Funeral Director		5. Social Security Number 6. Sex 243 28 9766 1 X	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	25, 1925	hirthplace (State or Foreign Country) North Carolin
30	d within 72 hours after death with the Maryland jiens trithen "natural", or iteme 23a or 28e-f ehow the Madical Examiner sual by notified a	by Funeral Director	10a. State Maryland Prince G 10e. Street and Number 3800 Hemlock Plac 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	eorge's		Hills 10f. Zip Code			United S 14. Race - Ar Black, W Specify:	tates merican India <i>n</i> ,
and 21215-0036	be filed within 72 hours tal Hygiene. d other then "natural! event, the Medical Ex	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	cation completed) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done OO NOT use retired	during most of world) 18. Mother's Nar		Maiden Sumame)	
Battimore, Maryla	permit. Pages 1 and 2 should t Department of Health and Meni Importent: if Item 27 is market eny Injury or other traumatic o	То	Quincey Troutm. 19a. Informant's Name/Relationship (Ty) Aaron Stout (Husb. 20a. Method of Disposition 1 Burial 2 Cremation 3 B 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	ope, Print) and) emoval from State Ma:	3800 Place of Disponentery, crer ryland	Hemlock sition (Name of natory or other place Veterans 2. Name and Addre	Place, To Aug 2, So Cemeter ss of Facility Lee	e Funeral	er, City or Town, State 111s, MD 20 20c. Location - City Cheltenhau Home, Inc	0748 or Town, State n, MD
/60,	Physician /Medical /Medical supplies prices and physician supplies prices from the prices of the pri	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death le cause on each line. Lepus Due to (or as a conseq Due to (or as a conseq Small Due to (or as a conseq And Adage	uence ol):					Approximate Interval Between Onset and Death
O. Box 68	he death certificate I the attending physiched for use as the t	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√ENNo 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3[Ectopic pregnanc Other (specify)	y		23d. Date of Month	delivery Day Year
٦.	The law requires that the death certifical ate has been signed by the attending phypage 2 should be delached for use as the	Completed by Ph	Part II. Other significant conditions con Meneroa Walnute	ntributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	1 🗆 24a. Was	Yes ZXNo 3 an 24b. Were prior	e to the cause of death? Probably 4
Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	25. Was case referred to medical examiner? 1					28c. Injury at Work? M 1 Yes 2 No			Pecify) Rural Route Number,
	Hospitel of 24 hours after the Funeral Dietely filled in	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day.								
-	To the vithin 2 To the complet	Me	29b. Signature and title of certifier				962116	>	29d. Date signed (M	
1) /	ate	30. Name and address of person who co Meklit Workneh, I 31. Date liled (Month, Day, Year)	MD 7705 Belle	Point	Drive, G	Greenbelt	, MD 207	770	
	Regist		AUG 0 3	32. Registrar's Signa 2007	. St.	fores.				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 **Physician** 5:30 A July 30. Strickland Joseph V. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Charlotte Hall 14545 Turnwood Place 8. Date of Birth Nov 1, 1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 578 42 1328 **Funeral** Washington DC 78 Director Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City, Town or Location 10b County 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and: if item 27 is marked other than "natural", or iteme 23s or 28s-f show ury or other than try or other than the natified and the na 1 ☐ Yes 2 No Charlotte Hall Charles Marvland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20622 14545 Turnwood Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WWI If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married XX Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Library of Congress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Smith Rudolph Strickland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14545 Turnwood Place, Charlotte Hall, MD 20622 19a. Informant's Name/Relationship (Type, Print) Ruth E. Strickland (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place Aug 3, 2007 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ortant: if Resurrection Cemetery Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lec Funerel Home Inc 663301d Alexandria Ferry Road, Clinton, MD 20735 permit.
Depertrainments
Imports
any nit 21. Signature of Funeral Service Licensee M00257 ous 26a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hepatic Necrosis Physician /Medical expi-1923 Due to (or as a consequence of): Examiner Hortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 30107 Examine physicien and the burial-transit The law requires that the death certificate be executed Hyperlipidenta Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. antingons Physician/Medical ettending ph IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 Unknown 1 ☐ Yes 2 🛣 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 24 No 1 ☐ Yes 2 ☐ No 1 Yes the Hospitel or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death | Check only one director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes XXNo 2 ER/Outpatient 3 DOA 1 Inpatient this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ANaturat 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 5 Pending 1 Tes 2 No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7130107 D35295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 St. Patrick Drive, Suite 208, Waldorf, MD 20603 Satish Jamani, M.D. 31. Date filed (Month, Day, Year) AUG 0 3 2007 32. Registrar's Signature State Male 14 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Evan Savatgy July 29 2007 1:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore Age (In yrs. last birthday)
77 Yrs. If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1**∑**M 2□F Hours Yrs June 6, Director 085-24-7547 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. wirt: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Tigerwood Court 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3. Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Technician Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Savatgy Caimer 0 Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Ailsa Avenue Baltimore, Maryland 21214 Barbara Nuth- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specity) Meadowridge Cemetery 8/2/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Baltimore, MD 21206 n 23a. Part1. Enter the disease or complications that caused to shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician URDSEPSIS DAYS /Medical Due to (or as a consequence of): Examiner PARKINSONS DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Funeral within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title D64395 July 29, 2007 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST. BALTIMORE, MO 21204 DANIEUE DOBERMAN, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 3 2007 Registrar

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				Maryland /		artment of H		Mental Hyg	iene	10.34	
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	Physici	an				0 1		2. Date of Dea Month	Day	Year	3. Time of Death
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	Examin	er	228 Bar Harbor Road	'7		Pasadena					I ob a
	Funeral		5. Social Security Number 6. Sex 7. /	Age (In yrs. last bi	irthday)	if Under 1 Year	If Under 24 Hrs	8. Date of Birth		Arur 9. Birthp	lace (State or Foreign
ш	Director		215-42 - 7079	63	Yrs.	Months Days	Hours Min.	(Month, Day NOV 24		Cour	vland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Lo	cation					0d. Inside City Limits
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	the 1 28a-	Director	Maryland Anne Arundel 10e. Street and Number		Pas	adena 10f. Zip Code		1	0g. Citizen of V	What Cour	ntry?
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	death	Funeral	11. Marital Status 12. Was Deceder Armed Forces	nt Ever in U.S.	13.	Was Decedent of His f Yes, specify Cuba		specify Yes or No-	14. Rac	e - Americ	
9	flied within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	/ Fu	1 Never Married 2 Married 1 Yes 2	X No		Tes, specify Cuba T⊡Yes 2⊠ No	Specify:	io Rican, etc.)		ck, White, v: Whi	
21215-0036	hours ural",	d by	3 Widowed 4 Divorced Year or Dates								
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/lar	uld be Menta Irked Itic ev	To B	William :	Schwartz			Sa	rah		Harl	in
Maryland	2 sho and i Is ma	ė v	19a. Informant's Name/Relationship (Type. Print)	191	b. Mailir	g Address (Street a	nd Number or R	ural Route Number	, City or Town,	State, Zip	Code)
≥,	and lealth m 27		<u>Ae S Schwartz</u> spoi		2	28 Bar Ha	rbor Ro	ad Pasade	na MD 2	21122	
0	it of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	e cemete	ery, crer	sition (Name of natory or other place	· : AIH	7 3 2007	20c. Location - Pasade		own, State aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Mt		el United	Heth Co	ēm 📗			•
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	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	at time of death		Other (specify)			Mo	nth	Day Year
<u>d.</u>	that the de led by the s detached f	Ph	Part II. Other significant conditions contributing to death	but not resulting i	n the ur	iderlying cause give	n in Part I	23e Did tol	acco use cont	ribute to th	ne cause of death?
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	Vith Voil	Σ	29b. Signature and title of certifier			29c. License	number	2	9d. Date signer	d (Month,	Day, Year)
)			1533			Doo	425	45	011	1.50	7 00
	6		30. Name and address of person who completed cause of	death (Item 23a)	(Type, I	Creen !	st B	sculfirm	MD	2	1201
	Sta Registr		31. Date filed (Morth, Day, Year) AUG 0 3 2007	trar's Signature	Spe	29c. License Dob Print)					

		1.	State of Maryland / Departi	ment of Health and N iicate of Death		ene g. No.	01.011
			Registrar Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
Phys /Me	siciar edica	100	Connie Shipman	o. City, Town, or Location of Death		28 2001 4c. County of Death	515 AM
Exa	mine	48	a. Facility Name (If not institution, give street and number) 4th	Hazerstown		Washington	Co.
Fune	ral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1-Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign ntry)
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Maryland d 2 should be file th and Mental Hy 7 Is marked oth		우	19a Informant's Name/Relationship (Type. Print) 19b. Mailing	Address (Street and Number or R	ural Route Number	r, City or Town, State, Z	ip Code)
and 2 and 2 nealth a n 27 Is			Patricia Shipman (sister) 1318	Montello A		2000 2 20c. Location - City or	own, State
more Pages 1 nent of H int: If Iter	5	2	20a. Method of Disposition 1 □ Bunal 2 Cremation 3 □ Removal from State	tory or other place)		Riverdal	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene." Important: If Item 27 in marked other than "natural", or Items 23a or 28a-f show with printed 25 and 15 a	once.	-		Hackett'S F			
a 88 5	5 5	_	one Part Start the disease or complications that caused the death. Do not enter				Approximate Interval Between
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/Medi	cal		disease or condition resulting in death) Due to (or as a consequence of):	/mmumo	Synd	mone	
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of cite.	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C				
8760, Cate be executed physician and	purial-t	E E	resulting in death) Last Due to (or as a consequence of):				
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I Records, P.O. Box 6 The law requires that the death certific ate has been signed by the attending to	or use	Physician/Me		ctopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
P.O. E hat the dead by the all	ched to	ysic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 0 9 ☐ Unknown	Julei (specify)			
IS, P.	o l	by Pr	Part II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.		obacco use contribute to Yes 2□No 3□Pi	
cord: w require	hould		Dysphagia		24a. Was	an 24h Were a	utonsy findings available
Rec The law		Completed				rmed? death?	completion of cause of 2 ☐ No
Vital Rediction: The law	ctor, p	BeC	25. Was case referred to medical examiner?	Other:	eath (Check only o		
Phys	ral director, page 2	2	1 Yes 2 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient 2. Inpatient	28c. Injury at Work?		dence 6 □Other (Spe how injury occurred	city)
Ing Afte	inne	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No			- Doub Alumbar
Division I or Attending after death. Director: Afte	in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stre building, etc. (Specify)	et, factory, <i>o</i> ffice	28f. Location (S City or Tox	Street and Number or R wn, State)	urai Route Numbei,
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	tely filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and pla estigation, in my opinion, death oc	ice, and due to the courred at the time,	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
othe l	omplet	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
F * F	O		> Fame much	006039	•	07/30/0	l
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, F	126 0 Acquist	Pal	m 217	140
5	Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature		,		
Re	egist	rar	ALIC O 3 2007 Deale So April				

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

		1 - State Registrar	ate of Marylan	-	artment of H			ene	01.02.1		
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Martha Mae	Thompson				2. Date of Death	De 2007 Year	3. Time of Death 5:01 A M		
Examin		4a. Facility Name (If not institution, give street Southern Maryland H			4b. City, Town, or Clinton If Under 1 Year	Location of Death		4c. County of Death Prince Geo	orge's		
Funeral Director		5. Social Security Number 415 56 3249 Usual Residence of Decedent	9. Birth Cour. 0, 1936 Geo	place (State or Foreign ntry) orgia							
a-f show ified at	ctor	10a. State 10b. County Maryland Charles	10c. City	, Town or Lo Waldo				10d. Inside City Li 1 ☐Yes XX			
23a or 28 ust be nol	ral Director	10e. Street and Number 2006 A Wedgewood P1	ace		10f. Zip Code 20602	2	100	Og. Citizen of What Country? United States			
al", or items xaminer m	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.: med Forces? ∐Yes 2M∏No Yes, Give ear or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:			
Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) ollege (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired, Slady	lurina most of worki	ing	Sb. Kind of Business/In Montgomery	·		
/ental Hygie rked other tic event, th	To Be Co	17. Father's Name (First, Middle, Last) UNKNOWN		<u> </u>		18. Mother's Name Sue Star	(First, Middle, Ma		waru		
ealth and N n 27 Is ma er trauma		19a. Informant's Name/Relationship (Type. P. William Thompson	. *	19b. Mailin 2006				City or Town, State, Zip rf, Mary lan			
ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State	emetery, cren ee Fun	sition (Name of natory or other place eral Home	Cremator	, 2007 c	C. Location - City or To 1	ryland		
Depart Import any inj once.		21. Signature of Funeyal Service Licenspe	10015	3 A1	Name and Addres	^{is of Facility} Lee Ferry Roa	Funeral ad, Clint	Home,Inc 6 on, MD 207	633 O1d 35		
ysician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final disease or condition resulting in death)	is that caused the death use on each line.	Do not ente	er the mode of dying C f + US	g, such as cardiac c	or respiratory arres	t,	Approximate Interval Between Onset and Death		
/ledical aminer ≅	ner	Due to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Lue to (or as a consequence of): C									
	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last		· · ·							
attending for use as	hysician/Medi	in the past 12 months?	yes, outcome pf pregnar □Live birth 2□Fetal □Pregnant at time of de □Unknown	death 3	Ectopic pregnancy			23d. Date of deliver	ery Day Year		
en signed b	by P	Part II. Other significant conditions contribut	cco use contribute to the								
page 2 sho	Completed						24a. Was an autopsy performe	prior to co death?	psy findings available mpletion of cause of		
ertific ector,	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)				
After this ouneral dire	ို	1 Natural 5 Pending	1 Manpatient 2 L	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at Nursing Hor	me 5 Residence 28d. Describe how	ce 6 ☐Other (Specifinjury occurred	y)		
uneral Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of injury - At hor building, etc. (Specify,	me, farm, stre)		′es 2□No	28f. Location (Stre City or Town,	et and Number or Rura State)	I Route Number,		
ne Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Care	To the best of my know in the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tim restigation, in my op	e, date and place, a pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as s e and place, and due to	tated. o the cause(s)		
Toth	Ž	29b. Signature and title of certifier	5		29c. License	number 16478		. Date signed (Month, 7-30-07)	Day, Year)		
0 '		30. Name and address of person who complet	e1.100 70	23a) (Type, F	erint)	Rd. O			20735		
Stat Registra		31. Date filed (Month, Day, Year) AUG 0 3 200	32. Registrar's Signati	ure	porte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death of nol Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Richard Vine11a Q. 27 05:41 M 0 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bactimore uivers 1ty secialty to Spital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1**X** M 2□ F 578-52-5634 65 Yrs Washington, D.C. August 1, 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12631 Circle Drive 20850 United States 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk National Geographic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent L. Vinella, Sr. Antonette Mastrangelo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent L. Vinella, Jr/Brother 12631 Circle Drive, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 1, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Dother (Specify) 2007 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service bicensee letter M01305 Samelin 23a. Part1. If there is disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oronon Due to (or as a conservence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumon (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

28a-f sh notified

ms 23a or must be r

2 should be filed within 72 hours after death v n and Mental Hygiene. Is marked other than "natural", or items 238

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

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burial-transit the attending physician hed for use as the buria detached ģ page 2 s

Physician/Medical

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Completed

Be

Certification: To

Medical

P.O. Box 68760,

Division or Vital Records,

Hospital or Attending

To the To the

filled in by

completely

10

certificate has been After this funeral hours after death. 24 hours after death Property Proctor: the

2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No

1 Natural

3 ☐ Suicide

4 Homicide

27. Manpér of Death 5 Pending investigation 2 Accident 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a, Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier aunes 29c, License number D0050 480

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZERA- Y OHANNES, 601 South Charles St, Baltimore, MD 2123 D 31. Date filed (Month, Day, Year)

State Registrar



Injury

				State of Mar		tificate of			ene Julia Ja	7 24922
	Physic		1. Decedent's Name (First, Middle, Last)	w.	14177	CE		2. Date of Deeth		3. Time of Death
	/Med Exami		4e Fecility Neme (If not institution, give :	street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of E	Death
			Vantage House				Columbia		Howan	ď
	Funeral Director		4/1-03-/383	7. Age (1	In yrs. last birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 2,	year) 9. 1915 M.	Birthplace (State or Foreign Country) innesota
	fand		Usuel Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Loc	cation				10d. Inside City Limits
	Mery	ţ	Maryland Howard		Columbia					1 ☐ Yes 2 ☑ No
	with the 3e or 28e	I Direc	10e. Street end Number 5400 Vantage Po	int Road		10f. Zip Code 2104	4	10	g. Citizen of Whe	t Country?
020	filed within 72 hours efter death with the Meryland Hygiene. ther than "naturel", or flems 23e or 28e-f show int, the Medical Exertiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wwidowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1	1	/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispenic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. White
21215-0020	in 72 hours eff n "naturel", or ledical Exem	pieted	15. Decedent's Educ (Specify only highest grade	eation completed)	944-47 16e. Decedo (Give k	ent's Usual Occup	ation during most of worki	ing 1	6b. Kind of Busine	
1212	be filed within 72 ho tal Hygiene. d other than "natur event, me Medical	Com	Elementary/Secondary (0-12)	Collage (1-4or 5+)		stered N	urse			alth
Maryland	B a a S	To Be	17. Father's Neme (First, Middle, Last) Carl Steenberg				18. Mother's Name Martl	na Peters		
	2 0 0 5		19a. Informant's Name/Relationship (Type Carla H. Clavelle				and Number or Rurs			te, <i>Zip Code)</i> 045
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 I		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	1:	20b. Place of Dispos cemetery, crem	ition (Name of atory or other place	e)	-	0c. Location - City	or Town, State
altin	permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Limited	• 2	Metro Cre	Name and Address			neral Hor	ore, Maryland
	80 5 8		Jubico C	OS	_ 55		Knolls Ro	d., Colur	mbia, Mar	ryland 21045
all in	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one				g, such es cardiac d	r respiratory arres	st,	Approximate Interval Between Onset and Death
Th.	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a.	DEBI	e to (or as a consequence of the SON	ence of):				
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x 68760, €	ertificate be executed ling physician and e as tha bunal-transit	8	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	DEM	to (or as a consequent	•				
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, P.O.	v raquiras thet tha daath cer been signed by the attendir should be detached for use	by Physician/N	Part II. Other eignificant conditione conti	libuting to death but no	ot resulting in the unc	derlying cause give	en in Part I.			ute to the cause of death? Probably 4 Dunknown
Division of Vital Records,	The law raquiras thet tha daath cer sta has been signed by the attendir paga 2 should be detached for use	Completed b						24a. Was an performe		b. Were autopsy findings available prior to completion of cause of death?
<u>65</u>	: The cetal							T□ Yes	2 LUNO	1 ☐ Yes 2 ☐ No
of Vit	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificeta has completely filled in by the funeral director, paga 2	To B	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Deeth		2 ER/Outpatient		4 Universing Hon	ne 5 Residen	ce 6 Dother (S	tage /tuse
sion	Attending r death. ector: After by the fune	Certification:	1	28e. Date of Injury (Month, Day Ye			res 2□No	8d. Describe how	r injury occurred	
DIV	tal or Attendi rs after death ai Director: A led in by the f	Certiff	4 Homicide determined	28e. Place of Injury - building, etc. (S		t, factory, office	2	8f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examine	r: On the best of my r: On the basis of exa and manner stated.	knowledge, death o mination and/or inve	occurred at the time stigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, date	se(s) and manner and place, and c	as stated. due to the cause(s)
	Vithin To th		29b. Signature and title of certifier	's res		29c. License	number	290	I. Date signed (Mo	onth, Day, Year)
	2	1	20. Name and address of several	ploted source of death	/ltem 00e) /T		2/8/		4931	12001
	10x		30. Name end address of person who com	Pleted cause of deeth	(Item 23e) (Type, Pr	GB	RETIM	OR=	NIND	1,2007 1201.
Att	Sta Registra		B1. Date filed (Month, Day, Year) AUG 0 3 2007	7. Registrar's	Signature Local	E)				7

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 000 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2007 July 31, 10:18p M Edmond Paul Wyatt 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Genesis Elder care Heritage Dundalk Social Security Number 213-26-5402 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1**X** M 2□ F Months Hours Days Min. NOV. 244, 1929 77 Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ¹∏Yes 2□No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 708 S. Umbra St. USA 21224 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🕱 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 yrs. Courier St. of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Newton Wyatt Marie Goetz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Concetta Wyatt wife 708 S. Umbra St. Baltimore Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore 2007 21. Signature of Fuperal Service License ^{22. Name and Address of Facility} Connelly Funeral Home of Dundalk 7110 Sollers Point Rd, 21222 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 245. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 25. Was case referred to medical examiner? 26 Place of Roth (Chack only one 2 No 1 ☐ Yes 27. Mann of Death

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with inner of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23a or 3 ury or other traumatic event, the Medical Examiner must be not so the traumatic event, the Medical Examiner must be not so the traumatic event.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

P

Md.

the Maryland

Physician/Medical Completed Be

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Certification: To

Medical

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

ate has been signed by the attending physician page 2 should be detached for use as the buria completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760

Attending Physician:

To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After it

State Registrar

				20.	I lace of Dea	sain (Check billy bile)
	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	□ DOA	Other: 4	Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
g gation		28b. Time of Injury N	28c.	Injury at Work? 1 ☐ Yes		28d. Describe how injury occurred
not be ined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, fa	factory, off	ice		28f. Location (Street and Number or Rural Route Numb City or Town, State)

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

NO cruse of death (Item 13a Type, Print)

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5 Pendir

6 Could

29c. License number

31. Date filed (Month, Day, Year) AUG

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #12, perFH, g870, 8/10/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Elmer O'Dell Williams Aug 1, 2007 5:20 p M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3701 Old North Point Rd. Lot 41 Dundalk Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2□ F 80 218-22-6700 Director Feb. 8, 1927 Va. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director Md. BAltimore Dundalk 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 3701 Old North Point Rd. Lot 41 21222 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or item Examiner Black, White, etc. Affiled Foldes: 1 □XYes •XIN• If Yes, Give Year or Dates: Army 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White ρ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Ship Yard 8 yrs. 17. Father's Name (*First, Middle, Last*) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Ray Williams Louise Deane ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Sellers 2415 Carolyne Ave. BAltimore Md. 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2 Aug. BAltimore Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Funeral Service License 21 Signature 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Suicido disease or condition resulting in death) Juns /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, The law requires that the death certificate be executed Exami burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner?

1 XYes 2 □ No funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Certification: To this 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury Augus71,2007 1720 P To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Tyes 2 Accident 3 Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28f. Location (Street and Number City of Town, State) 370 Dandal M 2 lace of injury - At home, farm, street, factory, office building, etc. (Specify) tomo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check only 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 3a) (Type, Print)

Registrar

State

Date filed (Month, Day, Year)

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32. Registrar's Signature

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ffe:	Funeral Director		5. Social Security Number 215–07–6046 Usual Residence of Deced		Sex 1 M 2 XF	Age (In yrs. la 97	Ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		ay, Year)		Cou	place (State ntry) yland	or Foreign
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	with th	Dire	10e. Street and Number 3800 Old (¹orana.	Do-J			10f. Zlp Code				izen of WI	nat Cou	ntry?	
	ms 23	Funeral	11. Marital Status	our t	12. Was Decede		S. 13. ¹	21208 Was Decedent of H If Yes, specify Cub		Specify Yes or N	US.		- Ameri	can Indian,	
396	be illed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2[3 Widowed 4 Di		Armed Force 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	No		lf Yes, specify Cub 1 □ Yes 2 T No	an, Mexican, Puer Specify:	to Rican, etc.)		Black Specify:	, White,	etc. White	
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Maryland	i 2 shou h and M 7 Is mar traumat		19a. Informant's Name/Re Rebecca Joh					ng Address (Street					tate, Zij	o Code)	
	Health Fem 27		20a. Method of Disposition	проп	Daugne	20b. Pla	ace of Dispo	Southway sition (Name of	t	Date Date			ity or T	own. State	
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Balti	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.		21. Signature of Funeral S				22	2. Name and Addre	ess of Facility L	oring By	ers	Fune	ral	Direc	tors.
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Or.	Attending Physician: r death. ector: After this certific. by the funeral director, I	မ	1 ☐ Yes 2 ☐ No 27. Manner of Death		Hospital: 1 ☐ Inpa 28a. Date of Ir		R/Outpatien 28b. Time of		4 Nursing H	lome 5 Res				fy)	
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Division or	l or Atter after dea Director	Certification:	3 Suicide 6 □	Could not be determined	28e. Place of I	njury - At hon etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or To	Street an wn, State	d Number	or Rura	al Route Nu	mber,
1	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Ce (Check only one)	rtifying Ph edical Exam	ysician: To the bes niner: On the basis and manner:	of examinati	riedge, death on and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	i e, and due to the urred at the time	cause(s	and man	ner as s	stated. to the cause	(s)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WARREN 30 20 d **Physician** Month 1:00 P M Lee 41145 Jul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore VA Medical CONTER NIA RALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) UIRGINIA Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 2□ F 214.24.2672 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at BALTIMORE 1 Yes 2 No MI by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with trent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 2 ury or other traumatic event, the Medical Examiner must be n 21204 XAMILTON AVE. 3802 US 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If #es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLIC Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ON & SHORE MAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN HENRY WARREN HATTIE un known ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3802 HAMILTON AVE, BALTIMORE, MD DARREN WARREN 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON TORES VET. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 12/07 BLUINGSMILLS MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Phillips funeral Home 1721-27 N. Monual ST. Bacternere, Md Z1217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) trobable Metastic **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any land cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the g Unknown 9 Unknown vate nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 III Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the

State Registrar 29b. Signature apetitle of certifier

30. Name and address of person

SANDRA 31. Date filed (Month, Day, Year)

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no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature,

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29c. License number

A441764350 17454

29d. Date signed (Month, Day, Year)

ION GREENE Street BALL: more , MD 21201

7-05839			oe or Print i						gible.	
Bobby Allen Wh	elcr	nel St 1- For State	ate of Maryl		rtment of <i>tificate of</i>		d Mental Hy		Cal	
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth				If Under 1 Year	If Under 24Hrs.	8. Date of Bir		9. Birthplace (State or oreign
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21215-0036 ould be filed within 72 hours after a Mental Hygene. s marked other than "natural", o ic eyent, the Medical Examiner n	Соп	17. Father's Name (First, Middle,					8.Mother's Name	(First, Middle, I	Maiden Surname)	
C 2 2 2 2 5	To Be	Bobby C.	Whelche	<u> </u>			Connie		enning	
○ 5 5 15 15 15 15 15 15 15 15 15 15 15 15	۲	19a. Informant's Name/Relations Bobby C. Welche		ther)					mber, City or Town, MD 21122	State, Zip Code)
re, MC s 1 and 2 s of Health an If item 27		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal f		Place of Disposi rematory or oth	ition (Name of cem ner place)	etery, Augu	ust 04	20c. Location - C	ity or Town, State
		4 Donation 5 Other Sp	pecify:	Me		dge Cemet	cery 2	007		, Maryland
Baltimo permit. Pag Department Important:		21. Signature of Funeral Service	Licensee /	61	22. N	ame and Address	of Facility St	talling	s Funeral	변위함2 P.A.
Physician		23a. Part I. Enter the disease, or	complications that of	aused the doalh.	Do not enter th	ne mode of dying, s	such as cardiac or	respiratory arr	est, shock, or heart	Approximate Interval
/Medical :aminer	3	failure. List only one cause Immediate Cause (Final disease		e and meth	adone in	toxication	. '			Between Onset and Death
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876 tificate ng phy as the	an/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	e 23c. If yes,	outcome of pregn pirth	_	al death 3	Ectopic pregnar	ncy	23d. Date of de Month	elivery Day Year
Box 68760, cleath certificate be exuple attending physician ed for use as the burnal	- 75 I			nant at time of dea	ath	ner (Specify)				
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed							24a. Was		re autopsy findings available or to completion of cause of
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ViSion Atte	ifica	V.	inguition.	7/30/2007 e of Injury - At ho	unk me, farm, stree	t, factory, office bu	ilding, etc.			or Rural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	29a. Certifier 1 Certifying Pt one) 2 Medical Example Certifying Pt Certifying Pt One) 2 Medical Example Certifying Pt One One One One One One One One One One	nysician: To the bearing. To the basis							
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d	ŀ	30. Name and address of person		•		Otroni B iii	A. MD 0155	24		
\forall	- 1	Laron Locke MD. As	ssisiant Medica	ıı ⊏xamıner	TITENN	otreet, Baitim	ore, MD 2120	J I		

32 Registrar's Signat fre

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Mary	•	rtificate of D			Reg. No.	
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year	3. Time of Death
/Medi		ALICE ELEANOR	APSEY				JULY	20, 2007	2:55 A. M
Exami	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or L			4c. County of Dea	
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Funeral Director		216-22-5901	M 212 F	n yrs. last birthday) 82 Yrs.		Hours Min.	DEC. 5	y, Year) C	(ARYLAND
aryland show	_	Usuel Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Ba-f.	cto	MD ALLEGA	ANY	CUMBERL					
with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
ath v	rai	805 CATSKILL AVI		ia	21502			U.S.A.	orican Indian
NOTE, MATYIATIG ZIZID-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland ti of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23e or 28a-1 show or other treumatic event, the Medical Examinating must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2☐XNo	Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occupati	on ring most of work	ing	16b. Kind of Business	/Industry
Fig. 1	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			HOME	
filed w Hygien Sther th		12		HO.	MEMAKER	O. Mathada Nome	· (First Middle	HOME , Maiden Sumame)	
Maryiand of 2 should be file th and Mental Hy th is marked oth treumatic event	Be	17. Father's Name (First, Middle, Last)			1		R BELLE		
should Ind Meni	ပ္	A. RENZ SUTTON	an Origan	10h Mailie	- Address (Street on			er, City or Town, State,	Zin Code)
Vicin		19a. Informant's Name/Relationship (Ty) LISA M. APSEY/Di			3			CUMBERLAND,	
1 and 1 Health Health tem 27	1 5	20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location - City of	
DESILIMOTE, permit. Pages 1 a Department of Hea Important: If Item any injury or othe		1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crer	natory or other place)		4 (0007		
Deficient Particular P		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			-ROCKY GAP		4/2007	FLINTSTO	DNE, MD
Demit. Departmingortal		1 Rand (D)	Gochus		UPCHURCH	FUNERAL	HOME,	P.A.	01500
		23a. Pert1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	death. Do not ent	202 GREEN er the mode of dving.	VE STREE	r CUMB	ERLAND, MD	Approximate
	şi.	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
Physician/Medical		disease or condition resulting in death)	12		Breca	t Core	2		yeur
Examiner			Due to (or as a co	onsequence or):					
	e e	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
uted ansit	Examiner	Cause (Disease or injury that initiated events							
execting and training and and training and t	Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
ficate be executed physician and the burial-transit	edical		J						
= 0 6									
death certif	by Physician/M	23b. was decedent pregnant	3c. If yes, outcome of p		Ectopic pregnancy			23d. Date of de	,
. 5 .0 5	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tim		Other (specify)			Month	Day Year
that the death cered by the attendir	hy	9 Unknown							
Of Vital necords, F.O Physician: The law requires that the r this cartificate has been signed by th rail director, page 2 should be detache		Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the u	nderlying cause given	in Part I.		tobacco use contribute Yes 2 <u>□No</u> 3□F	Probably 4 Unknown
aw recast been as been 2 short	Completed						24a. Was	an 24b. Were a	autopsy findings available completion of cause of
The law rate has b	mo						auto perfe 1 ☐ Yes	ormed? death?	s 2 No
vician: The certificate rector, pag	a	25. Was case referred to medical				26. Place of Deat			
Of VITA Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	lospital:	2 ER/Outpatier	nt 3 DOA Other	4-Mursing Ho	me 5 Res	idence 6 Other (Sp	ecity)
on or ding Phys		27. Manner of Death 1. ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time o	f 28c. Injury a Work?	at	28d. Describe	how injury occurred	
Attending r death. sctor: After	atic	2 Accident investigation	(,)	,		s 2 No			
DIVISION I or Attending after death. Director: Afte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	reet, factory, office		28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
DIVISION To the Hospital or Attention 24 hours after death To the Funeral Director: completely filled in by the	edical C			amination and/or in				cause(s) and manner a date and place, and du	
To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mor	nth, Day, Year)
F ≯ F ŏ		F-94	こかの		000	17565	-	July 20	2007
		30. Name and address of person who co		h (Item 23a) (Tyne	Print)	17565		/ /	
10		ATDUCIAN TO	922 N	1271 14	ay Li	10212	, ng	215-62	
S	ate	31. Date filed (Month. Day, Year)	2. Registrar's	Signature	4				
Regist		AUG 0 3 2007	15 m 68 1	1. Das					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ORES A. BRENNAN 19.58 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SIEN BURNE If Under 1 Year II Under 24 Hr OMBARDEE Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days Hours 1 ☐ M 2 🗗 F Months Min 215-28-0123 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 W No MD ADENA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21122 2.5.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: whiTE Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HELENA FITZGEROLD FREDERICK W. REMBOLD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARISTOPHER BRENNAN, SON CT. Ellicott CITY, MD. 21043 8304 WHITEBARK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 Buria. 4 Donation 5 Other (Special) Cinnature of Fundial Service License -30-07 ROENT CREMATORY HANDVER MD. 21. Signatu 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part 1. Enter the disease of complications that leaded that death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) egy Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Y Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Special Special 1 Inpatient 2 ER/Outpatient 3 DOA

To the Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit and attending physician the ģ certificate has funeral director, After this Director: within 24 hours a To the Funarel D

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Completed by Funeral

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Funeral

Director

itam 27 is marked other then "natural", or items 23a or 28a-f show other traumatic avent. The Medical Examinar must be notified at

death with the Maryland

72 hours after

d 2 should be filed within ; th and Mental Hygiene. 7 Is marked other then "r

Pages 1 and 2 s ment of Health an

itam 27

Important: If it, any injury or o once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Physiclan/Medical IF FEMALE S Completed Be

Certification; To

cal

Medi

Examiner

25. Was case referred to medical examiner? 1 🗌 Yes

Manner of Death Natural 5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

М 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAG 305

State Registrar

31. Date filed (Month, Day, Year) NIG 0 3 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** William Burton 906 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice at the Lake Wicomico Jalisburg oastal If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1**X**M 2□ F Director 70 025-28-9722 6/15/1937 Massachusetts Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits notified at 1 ☐Yes 2 ☐ No Director Maryland Wicomico Salisbury 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Examiner must be 21804 307 Brookdale Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify. 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>maintenance</u> <u>maintenance</u> person Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental William Burton Helen Syrette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important; If Item 27 Is Kevin Burton/son 38 Edgeworth St., Weymouth, MA 02189 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State 20a. Method of Disposition injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 7/19/2007 Salisbury, MD 21. Signature of Funeral Service Licent Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 any Well 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Victostall /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9∏Unknown 9 I Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown Completed peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No certificate has page 2 autops 10 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 🔰 No 2 ER/Outpatient 3 DOA 2 this funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Injury 1 Natural 5 ☐ Pending investigation within 24 hours area ... 7 To the Funeral Director: Af 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the I

Registrar

29c. License number

Name and address of person who completed cause of death (Item 23a) (Type, Print)

mstel

and manner stated.

ith, Day, Year) JUL 1 9 2007

				ryland / Depa	artment of Health and		•	31.533		
		Registrar		Ce	rtificate of Death		g. No.	6-H205		
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Donald Lee Bur	rton			2. Date of Death Month July	Day Year 18 2007	3. Time of Death 7:55 p. M		
Examin	_	4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or Location of D	eath	4c. County of Death	-		
		Chesapeake Woods	S Center		Cambridge		Dorches			
Funeral Director		217-28-2802	7. Age	(In yrs. last birthday) 74 Yrs.	If Under 1 Year If Under 24 If Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, Sept. 2,	Year) 9. Birth Cou 1932 Mai	year) 9. Birthplace (State or Foreign Country) Maryland		
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Dorches	ter	10c. City, Town or Lo	cation Cambridg	je		10d. Inside City Limits 1 ☐ Yes 2 XNo		
with the 3a or 28a-	Director	10e. Street and Number 112 Richardson D	rive		10f. Zip Code 21613	10	g. Citizen of What Cou USA	Citizen of What Country?		
d 21213-UU36 filed within 72 hours after death with the Maryland Hygiene. Hygiene. ither then "natural", or Items 23a or 28e-f show ant, Ite Madical Executive confits of at	by Funeral	11. Marital Status 1 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 MYes 2 N If Yes, Give Year or Dates: 1	0	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi 1 ☐ Yes 2 ☑ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black, White	14. Race - American Indian, Black, White, etc. Specify: white		
ING 21213-UU36 be filed within 72 hours af tal Hygiene. d other then "natural", or event, the Medical Exteri-	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of DO NOT use retired)	6b. Kind of Business/Ir				
filed wi Hygien ther th int, tre	9	11			dietary worker		state hosp	oital		
d be antal	To Be	17. Father's Name (First, Middle, Last) John Riley Burto	n Sr.			Name (First, Middle, N La Jones	laiden Sumame)			
and and and and and and and and and and		19a. Informant's Name/Relationship (Type	•	1	ng Address (Street and Number of			o Code)		
re, Mary s 1 and 2 shoul f Health and M ltem 27 Is marl other traumati		Darlene Burton	wife	and the same of th	Richardson Drive					
Baltimore, sermit. Pages 1 a Department of Hec mportant: If them in y injury or othe page.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		psition (Name of matory or other place) Market Cem. 7		Oc. Location - City or T			
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signatur Funeral Service License		2:	2. Name and Address of Facility 700 Locust St.,	Thomas Fun	eral Home I			
Physician		23a. Part Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line Rena	a	er the mode of dying, such as car adeno carch	•	st,	Approximate Interval Between Onset and Death		
ate be executed ate be executed by sician and be burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
Hecords, P.O. Box 687. The law requires that the death certificate lite has been signed by the attending physicage 2 should be detached for use as the control of the contr	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	rery Day Year		
id be detached	þ	Part II. Other significant conditions confidence by perten 5					acco use contribute to s 2 □ No 3 □ Pro	the cause of death?		
VITAI HECONDS, ritian: The law requires to certificate has been signedirector, page 2 should be considered.	Completed	hypertens atrial fil	bnllztio	n	, ,	24a. Was ar autops perform	prior to c death?	opsy findings available ompletion of cause of		
	BeC	25. Was case referred to medical			26 Place of	1 ☐ Yes 2		2□ No		
ysicia ysicia is cer direct	To B	examiner?	ospital:	nt 2□ ER/Outpatie		ng Home 5 ☐ Reside		fv)		
DIVISION OF I or Attending Physiatier death. Director: Atter this d in by the funeral d		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 28b. Time o		28d. Describe ho				
DIVIS al or Atte s after det il Directo od in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, st (Specify)	reet, factory, office	28f. Location (Sti City or Town	reet and Number or Rui , State)	ral Route Number,		
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifica completely filled in by the funeral director, to	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner stat	examination and/or in	h occurred at the time, date and p vestigation, in my opinion, death of	place, and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)		
To the withing To the comp	Me	29b. Signature and title of certifier	do		29c. License number #005997		od. Date signed (Month			
		30. Name and address of person who con Patricia Johns	mpleted cause of de	ath (Item 23a) (Type,	HOOS997 St Camb	ridge Mi	2			
Sta Registr	17	31. Date filed (Month, Day, Year)	JZ. Heyisi	's Signature	porte					

			For State Registrar	State of Marylar		artment of F tificate of I		•	giene Reg. No.	-		
	D. D.		1. Decedent's Name (First, Middle, La	st)				2. Date of De	eath (UUT	3. Time of Death	
	Physicia /Medic		Diane Buchana	an				July	Day	200°7	1837 м	
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
			Memorial Hospital Easton Talbot									
	Funeral		Social Security Number 6. S	Sex 7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Yea <i>r)</i>	9. Birthp Cour	place (State or Foreign ntry)	
Z I	Director		094-48-6163 Usual Residence of Decedent	54	110.			Apr. 17	7, 195	3 New	/ York	
5	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits	
1,0	Maryland I-f show fied at	ţ	MD Carol:	ine		Ridgely					1 □Yes 2 XNo	
21.3	n 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	ntry?	
53	death with the ms 23a or 28a r must be notif		13049 Crouse 1	Mill Road			21660			USA		
200	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an. Mexican, Puerto	pecify Yes or No	₎₋ 14.	Race - Americ Black, White,		
(A) 90	or ite		Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:			ecify: whi		
~~6	72 hours 'natural'', dical Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	160 Doors	lantin Havel Oncor	-4:					
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75	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		adminis			a	irline		
200	be filed within 72 hours after death with the Marylar tal Hygiene. Ind other than "natural", or items 23a or 28a-f show of event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,				
Suchana, aryland 21215	fental fental rked o	To B	Royden Buchana	an			Helen	Rerat				
Suchana/ Maryland 21215	2 should be filed and Mental Hygi is marked other aumatic event, ti		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	g Address (Street	and Number or Ru	ral Route Numb	er, City or To	own, State, Zip	Code)	
Σ	and 2 ealth n 27 i		Scott Buchanan	brother	334 S	. 6th St	., Linder			1757		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other plac		Date	20c. Locati	ion - City or To	own, State	
Ë	tment tant;		4 ☐ Donation 5 ☐ Other (Special	y) Ro		Cemeter	4 .	4/07	Lynbi	rook, N	Ϋ́	
Baltimore,	permit. Pages 1 and 2 should be De, artment of Health and Memts Important: If Item 27 is marked any injury or other traumatic eronse.		21. Signature of Funeral Service Licer	nsee	- 1	. Name and Addre					.A.	
1	40 = 60		23a Parti Enter the disease or com	plications that caused the doa		00 Locust				21613	Approximate	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final			er the mode or dyn	ig, such as calulac	or respiratory a	iiiesi,		interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. SFP:								
7	Examiner					IC BRE	FAST C	ANCE	2			
100		Ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec		101-0	.,,,,					
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68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d								
ý ×	ertific ling p		IF FEMALE:	000 16 100 01 100 01								
Вох	leath certi attending I for use a	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn	al death 3	Ectopic pregnancy	1		23d	 Date of delive Month 	ery Day Year	
o.	at the de by the	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify) _						
٦.	that i		Part II. Other significant conditions	contributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did t	tobacco use	contribute to th	he cause of death?	
rds	quires than signed to all the det	d by						10	Yes 2	√o 3□Prot	ably 4 Unknown	
000	aw requir s been si s should	lete						24a. Was	an 2	4b. Were auto	psy findings available	
æ	The lav	Completed						autoj perfo 1∐ Yes	ormed?	prior to cor death? 1 ∐ Yes	mpletion of cause of	
ita		a	25. Was case referred to medical				26. Place of Dea			10163	219140	
>	g is	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2] ER/Outpatien	t 3 DOA Oth	er: 4 Nursing H	ome 5□Resi	dence 6 [Other (Specif	'y)	
0 U	ding Ph n. After th funeral		27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe	how injury or	courred		
Sio	Attending r death. ector: After by the funer	catic	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No					
	늘 의 느 ㄷ	Certification:	4 Homicide determined		nome, farm, str <i>ify)</i>	eet, factory, office		28f. Location (a City or Tou	Street and N wn, State)	umber or Rura	al Route Number,	
	Hospital or 24 hours afte Funeral Dir tely filled in		29a, Certifier 1 Certifying Pt	nysician: To the best of my kn	owledge death	occurred at the tir	no date and place	and due to the	cause(s) an	d manner as a	tated	
	e Hos 24 hc e Fun letely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time,	, date and pla	ace, and due to	o the cause(s)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date si	igned (Month,	Day, Year)	
			1 John Bots	us a		700	59487		07/1	17/20	07	
			30. Name and iddress of person who			Print)			/			
			John Botsis, M			ton St.,	Easton,	MD 216	01			
	Sta Registr		31. Date filed (Month, Day, Year)	32 egistrar's Sign	ature	and a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 23a per dr., g870, 08/16/97-dbbDeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Butto MEHON 2007 5:55 AM July 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Wicomico Salisbury Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Hours 1**⊠**M 2□F 224-40-8812 CAROLINA Director 9-4-1935 NORTH Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Wiermico ARHAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S. UPPER FERRY ROAD 21822 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No If Yes, Give Year or Dates: 1956 -1958 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No δ BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) NONE LABORER 06 item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HNOREW ARENCE MARY 2 1,9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FERRY ROAD Upper ERONICA 4520 Eden, Md. DAUGHTER 21873 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-20-07 4 Donation 5 Dother (Specify) DALISBURY (REMATORY 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Stewart Funeral Stewar Splis, Md, 2180 Home 821 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HY POXEMIC Immediate Cause (Final FAILURE. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Olivopontocerebellar Degeneration 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an death? 1 ☐ Yes 2 ☐ No certificate 2 40 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Warsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes \2 ☐ Ño 10 1 | Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18/07 10063199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yogesh Votra M.D. 614 Easternshore Dr Salisbury MD 21804

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

1 9 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Regina Brown **Physician** 2007 7 \mathbb{A}^{M} Ju1y 19 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Solomons Nursing Center Solomons 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 💆 F Months Hours Min. 213-38-0310 97 Yrs Aug 11, 1909 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Examiner must be notified at MD Calvert 1 ☐ Yes 2X No Owings Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9001 Boyds Turn Road 20736 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Principal Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Brown Mary Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherman Brown /Cousin 804 Homestead Avenue Hampton, VA 23661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 07/23/07 Dunkirk, MD Southern Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Faci Sewell Funeral Home Bladys G. Seyel 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) crobro **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐Unknown 9 Unknown ģ Panelt: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Alzhermer Demenha 21110 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy perform 2 No or Vital To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 Vo Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 🗌 Yes 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

DHMH 17 Rev 1/2001

21051

10 Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNSHIMD

29c. License number

PRINCE FREDERICK

/1				
State of Maryland /	Department	of Healt	h and Me	ental Hygiene

			1 - For State Registrar		State of M	Ce	artment of rtificate of			giene Reg. No.	07	24335	
	Physici /Medio		1. Decedent's Name	e (First, Middle, La RENAT		OTTALI CO			2. Date of De Month JULY	Day	Year 2007	3. Time of Death 6:00 A ^M	
	Examir		4a. Facility Name (/	f not institution, gi	ve street and number,)	4b. City, Town,	or Location of Dea	ıth	4c. County	of Death		
					RSING HOMI	3	KEN	SINGTON	MONTGOMERY				
and the second	Funeral Director		5. Social Security N	5744	Sex 7. A(1 ☐ M 2 X] F	ge (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th y, Year) 5,1938	9. Birthpl Count GERN	lace (State or Foreign try) 1ANY	
	and w		Usual Residence of 10a. State	10b. County		10c. City, Town or Lo	cation				1/	0d. Inside City Limits	
	Maryl f sho ed al	ō	MD.	DDINCE	CEODCEC	, n	LADENGRI	D.O.				1 XYes 2 □ No	
	the I	Director	10e. Street and Nur	PRINCE	GEURGES	D.	10f. Zip Code	KG		10g. Citizen of	tor2		
	with Sa or t be				CT #202		710						
	ns 2: mus	Funeral	11. Marital Status	EFIEKSUN	ST. #202	Ever in U.S. 13.		710 Hispanic Origin? (Specify Yes or No		A. ce - America	an Indian.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by		ied 2 Married 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No	er in U.S. 13. Was Decedent of Hispanic Original Yes, specify Cuban, Mexican 1 □ Yes 2 ▼No Specify:			Specify Specify	ck, White, e	etc.	
ŏ	2 hor	Completed	/6===	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of B			
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pu	be filed within 72 hortal Hygiene. dother than "natuevent, the Medical	Be (17. Father's Name	(First, Middle, Las	t)			18. Mother's Na	ame (First, Middle,	Maiden Surnan	ne)		
Maryland		2	W	ILLI	BRETTSO	HNEIDER		Al	NNA	KLOTZ	:		
lan)	2 sho and I is ma	7 9	19a. Informant's Na	ame/Relationship	(Type. Print)	19b. Mailir	ng Address (Stree	t and Number or F	Rural Route Numbe	er, City or Town,	State, Zip	Code)	
	rt 2 gad		INGRID	BRETT/	SISTER			RD., HY	ATTSVILLE	E, MD. 2	0783		
ore	0 0		20a. Method of Disp		☐Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	ace)	Date	20c. Location -	wn, State		
Ĕ	Pag nent ant; I ury o			5 ☐ Other (Speci			S CREMATO	ORY 7-20	0-2007	RIVERD	ALE,	MD.	
Baltimore,	permit, Pag Department Important; I any injury o		21. Signature of Fu	neral Service Lice	Mulled	M00091	Name and Addr CHAMBERS	ess of Facility FUNERAL VELAND AV	HOME & C	REMATOR	TUM.P	.A.	
9		1	23a. Part1. Enter th	ne disease, or con	nplications that cause	d the death. Do not ent						Approximate	
4	Physician	0 2	Immediate Cause (one cause on each li	me. ULAR FIBRII	TATTON					Interval Between Onset and Death	
	/Medical		resulting in death)	-	a	a consequence of):	TIMITON				-		
e e	Examiner		CHRONIC OBSTRUCTIVE PULMONARY DISEASE										
J. Car		ner	Secure dially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	nd	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
Ö,	e exe ian a urial-t	Ä	resulting in death) L	ast	Due to (or as	a consequence of):							
68760,	tificate be executed g physician and as the burial-transit	edical			_d								
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o.	the de	ysic	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	XNo	4□Pregnant a 9□Unknown	t time of death 5L	Other (specify) _					- Tou	
Δ.	that the de led by the a detached			cant conditions	contributing to death h	out not resulting in the ur	nderlying cause giv	von in Part I	23e Did to	phaceo use cont	ributo to the	e cause of death?	
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3e	e la has je 2	ld L							24a. Was autop	sy	prior to com	sy findings available pletion of cause of	
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Ž	iciar certif ectol	Be	25. Was case referr examiner?		Hospital:		Tout		ath (Check only o				
0	Physician; this certific ral director,	은	1 ☐ Yes 2 📉		I Inpatie		, oll box		Home 5 ☐ Resid)	
n	ding Physician; th. : After this certifica funeral director, p	Ö	1 XNatural	5 Pending	28a. Date of Inju (Month, Da		Wo		28d. Describe h	ow injury occurr	red		
Sic	Attending r death. ector: After y the funer	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not b		At home form also]Yes 2 □ No	fact in the				
Division	Ital or A	Certification:	4 ☐ Homicide	determined	Zoe. Flace of Inj	ury - At home, farm, street. (Specify)	eet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rural	Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	1X Certifying Ph 2☐ Medical Exa	nysician: To the best miner: On the basis o and manner st	of my knowledge, death of examination and/or invaled.	occurred at the to vestigation, in my	ime, date and place opinion, death occ	ce, and due to the courred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)	
	To the within To the comply	Ž	29b. Signature and	title of certifier	11		29c. Licens	se number	2	29d. Date signed	d (Month, E	Day, Year)	
	6		•	1	, () [. /	НОС	51280		JULY	18, 20	007	
	4	Ì	30. Name and addre	ess of person who	completed cause of d	lesth (Item 23a) (Type, I	Print)						
_					OGAR, D.O.	9715 ME	DICAL CE	ENTER DR.	,#201, R	OCKVILL	E, MD	. 20850	
	Sta		31. Date filed (Mont	h, Day, Year)	32 Registr	ar's Signature	A G						
	Registr	27	588	F 2 0 200	LE INCO	FT STAR	140 A						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death **Physician** Month Day Year JULY 2007 12:15 P 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5225 POOKS HILL ROAD #1615N **BETHESDA** MONTGOMERY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 04/27/1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Min. 90 Director 115-09-9254 NEW YORK Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo MD MONTGOMERY **BETHESDA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 5225 POOKS HILL ROAD #1615 N 20814 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE þ Specify: 3 ☐ Widowed 4 € Divorced Completed permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID WARSH ۵ IDA DORF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10116 WEATHERWOOD COURT, POTOMAC, MARYLAND IDA SUE STARKE/DAUGHTER 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition. Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State GARDEN OF REMEMBRANCE 7/20/2007 4 ☐ Donation 5 ☐ Other (Specify) CLARKSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a METASTATIC BREAST CANCER 3 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1∐ Yes 2 TxNo director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1X Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl • Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. within 2. 29b. Signature and title of contifier 29c. License number 2 29d. Date signed (Month, Day, Year) D0033293 JULY 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. FREDERICK P. SMITH, 5454 WISCONSIN AVENUE, SUITE 1300, CHEVY CHASE, MD 20815 31. Date filed (Month, Day, Year)

JUL 2 0 2007 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 3 25 PM ALBOUT CLANK 2007 /Medical 26 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MANY LAM MONICAL Conson DNIVERSIN BACAMONE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 □ F 215-42-1720 64 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at Director 1 ☐ Yes 2 No MD. Harford Bel Air 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 148 Maulsby Avenue Funeral 21014 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ Specify: 3 Widowed 4 Divorced 1966 White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Aberdeen College (1-4or 5+) Technical Engineer Proving Ground 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Thomas Leonard Clark ၉ Anna Marie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra (Wife) Patricia C. Clark 148 Maulsby Ave. Bel Air, MD. 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carroll Cremation 8/4/2007 Hampstead, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service tricensee 22. Name and Address of Facility Jarrettsville, Maryland Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PULMOWARY 4>ENTENSION /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ▼Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy certificate performed' 1XYes 2 🗆 No 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2**№** No 1 Nnpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t completely the 0

9+1

State Registrar 29b. Signature and t

SMA ZZ 31. Date filed (Month, Day, Year) AUG 0 3 2007

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

5. 32. Registrar's Signature

29c. License number

D64003

SMEE

NAW94

29d. Date signed (Month, Day, Year)

MA

21201

BAIRMONE

26

William P. Cawe 579-16-6848 Baltimore, Maryland 21215-0036

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38760,
Box (
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Records
or Vital
Division

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		For 1 _ State	State of Ma		Department of H		lental Hyg	jiene	-,
	-	Registrar 1. Decedent's Name (First, Middle, L	ast)		Certificate of	Deam	2. Date of Dea	th	3. Time of Death
Physici		William P. Cre	,				Month 07	Day	Year 1809 P M
/Medic Examin		4a. Eacility Name (If not institution, g			4b. City, Town, o	or Location of Death		4c. County of	
12, 4		PENINSULA REGION				BURY		Wico.	
Funeral Director		5. Social Security Number 6. 579–16–6848	Sex 7. Ago 1 X M 2 □ F	e (In yrs. last birl 85	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11-28-1	, Year)	9. Birthplace (State or Foreign Country)
±a hara		Usual Residence of Decedent					11-20-1	1921 M	ırrayville,PA
arylar show ed at	'n	10a. State 10b. County		10c. City, Towr					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
the M 28a-f notifie	Director	Delaware Sussex 10e. Street and Number		Seafor	d10f. Zip Code		14	0g. Citizen of Wh	
h with 23a or st be		6858 Atlanta Cir	c1e		19973			USA	ia. Oddina y i
r deat ems 3	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of H	Hispanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian, White, etc.
permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	1943	1 ☐ Yes 21X No		, , , , , , , , , , , , , , , , , , , ,	Specify:	White
72 hc "natul	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	oation during most of work	ing	16b. Kind of Busi	iness/Industry
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illed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Las			Attorney -U	18. Mother's Name		Legal S Maiden Surname	
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2 sho and l		19a. Informant's Name/Relationship Averill Crewe ((Type. Print) Vife)		Mailing Address (Street				
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mit. F partm portar y Injur		21. Signature of Funeral Service Lice		Oud Fe	22. Name and Addre		-2007		Delaware
	(2)	Tholly Short	- Dannia	on				H. Laure	el, De. 19956
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be es			,	a consequence o	n).				
The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medical		_d						
th cer tendin	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐Live birth		3 □Ectopic pregnancy	v		23d. Date	· · · · · · · · · · · · · · · · · · ·
ne dea the at hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown		5 ☐ Other (specify)			Monti	h Day Year
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sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		104	26. Place of Death	(Check only on	e)	
Phys r this ral dir	5	1 Yes 2 No 27. Manner of Death	28a. Date of Injur			4 LI Nursing Ho		ence 6 Other	
nding P tth. r: After i e funera	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) In	jury Wor	k? Yes 2 □ No	EGG. BOOGHBO HE	w mjary boodined	
r Atte er des irecto	Certification:	3 Suicide 6 Could not l 4 Homicide determined			m, street, factory, office		28f. Location (St City or Town		or Rural Route Number,
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and	death occurred at the tire divided in the tire divided in the tire death of the tire death of the tire death occurred at the tire	me, date and place, ppinion, death occur	and due to the cared at the time, d	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)
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Stat	te	21 Date filed (Month, Day, Vearle	20/ 32 Registra	r's Signature	Sperle	54613	bury m		
Registra		JUL 2 0 2	2007 September 1	U.B.	Aparle				

	1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of Hertificate of L		-	giene Reg. No.	· · ·	*, 5	1,		
sician	Decedent's Name (First, Middle DOROT		СНАРМА	N		2. Date of De	ath 15, Day 200	7 Year	3. Time of De 6:40 P	ath		
edical miner	4a. Facility Name (If not institution Renaissance Ga	, give street and number,		4b. City, Town, or	Location of Deat		4c. Count	y of Death				
ral tor	5. Social Security Number 578-22-3330 Usual Residence of Decedent	6. Sex 7. A	ge (<i>In yrs. last birthday,</i> 4 Yrs.	Months Days	if Under 24 Hrs Hours Min.		th y, Year) 1922	9. Birthp Coun Nebr	lace (State or Fo try) aska	ore		
ctor	10a. State 10b. County MD Montgo	mery	10c. City, Town or Lo					10d. Inside City Limits 1				
Funeral Director	10e. Street and Number 3114 Gracefield	Road, #316		10f. Zip Code	0904		10g. Citizen of United					
by Funer	11. Marital Status 1 □ Never Married 2 Marr 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces ied 1 □ Yes 2 🕅 If Yes, Give Year or Dates:	No.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		ce - Americack, White, e				
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To Be (17. Father's Name (First, Middle, George B	Last) Oyd			Pearl	me (First, Middle,	Groves					
To Be Completed by Funeral Director	Pa. Informant's Name/Relations Russell B. Chap 20a. Method of Disposition 1 Burial 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service	man - husba 3 Removar from State	nd 3114 20b. Place of Disponderly, cre Parklawn 2	ng Address (Street a Gracefiel Gracefiel Grader of Indianatory or other place Memorial 2. Name and Address 1800 New H	d Rd., Park 7/ s of Facility Hi	#316 Sil Date 19/07 nes-Rino	ver Spr 20c. Location Rockvis Udi Fur	ing, City or Too Cle, M	MD 2090 wn, State Maryland Home, I	l !n		
dical Examiner	23a. Part1. Enter the disease or shock, or heart failure. Let Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. ALZHE Due to (or as b. Due to (or as	IMER'S DISE a consequence of): a consequence of): a consequence of):						Inférval Betwee Onset and Dea Y CATS	ith		
sian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>				ate of delive	ry Day Yea	ir		
þ	Part II. Other significant condition DY SPHAGIA	ns contributing to death t	out not resulting in the u	inderlying cause giver	n in Part I.	23e. Did to	V		e cause of deat			
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Il Certification: To	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of Inju	ury 28b. Time o	f 28c. Injury	4 Nursing F	lome 5 Resident			")			
ıţţ	3 Suicide 6 Could n 4 Homicide determi	ned building, et	ury - At home, farm, sti tc. <i>(Specify)</i>			28f. Location (\$ City or Tox	vn, State)			;		
	29a. Certifier 1 Certifyin	g Physician: To the best Examiner: On the basis of	of examination and/or in	h occurred at the time evestigation, in my op	e, date and place inion, death occi	e, and due to the urred at the time,	cause(s) and m date and place,	anner as st , and due to	ated. the cause(s)			
	one)	and manner st	ated.							_		
			ated.	29c. License			29d. Date signe					

■ Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	Baltimore, Maryland 21215-0036		į
Ph	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland		j
v	Department of Health and Mental Hygiene.	F Di	
sic	Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show	un re	E×
ei a	any Injury or other traumatic event, the Medical Examiner must be notified at	ct	aı
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/Medical Examine

within 2

Division or Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician Month MICHAEL 12:15 A M JOHN CLARK Ju₁y 16 2007 lical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death iner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 1 M M 2 □ F 60 217-44-8870 Sept.8, 1946 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 U.S.A. 1909 Rockland Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Na Yes 2 No 1964
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White <u>Ş</u> 3 ☐ Widowed 4 ☑ Divorced 1968 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Salesperson Plumbing Supplies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph John Clark Helen Lako 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Atwood/Daughter 411 Norwood Road, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 07/23/2007 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses Nancu 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

75(HEM2C CARDZOM YUPAT HIY) Approximate Interval Between Onset and Death 8 HOLRS Due to (or as a consequence of): ARIGAY DISENSE 10 YEARS CEREN ARY Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a our sequence of): Examine The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 INJUFFICZENCY 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐Yes 2 No 1□ Yes 2 X No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1.2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Injury 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mar D23630 JULY 17, 2007 あんり 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCE J. MAYE, MD 16220 FREDERICK RD \$213, 6AITHERSBURG, MARYLAND 20877

31. Date filed (Month, Day, Year) JUL 2 0 2007 Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar 19a per FH/wichd/7-24-07/d1s Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Fulton Edward Dashiell 2007 54/4 /Medical Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death KEGIONAL DALISBURY ENTER NICOMICS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 83 Dec. 20, 1923 Director 219-07-7751 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a, State 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 423 Hearne Lane 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 No 1946 If Yes, Give 1946 Year or Dates: Feb. 11, 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Lvon Conklin 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Atwood Dashiell, Sr. Lillie Bell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Gwendolyn Dashiell/ Sister 1105 Parsons Road Apt. E - Salisbury, Maryland 21801 permit. Pages 1 an Department of Heali Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cem. July 25, 07 Hurlock, MD 21. Sign, ur of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road Jolley Memorial Chapel, P.A. - Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COLON CANCER METAS YEARS /Medical Due to (or as a consequence of): Examiner OBSTRUCTIVE LYNG DISEASE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by YPERTENSION 24a. Was an autopsy

The law requires that the death certificate be executed page certificate the Hospital or Attending Physician: After this within 24 hours aner control of the Funeral Director: Aft

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

Year

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No perform 26. Place of Death (Check only one)

25. Was case referred to medical examiner' 1 ☐ Yes 2 10 27. Manner of Death

2 FR/Outpatient 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

BAUTISTA 101-B MARKET STREET, POCOMOKE CITY, MD 2/851 VIRGILIU 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Be

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Certification:

Medical

Division or Vital Records, P.O. Box 68760 To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by To the Fune completely f

> 30. Name and add s of person who completed cause of death (Item 23a) (Type, Print) David 760 Carrol Bobby 31. Date filed (Month, Day, Year)
>
> JUL 2 0 2007 Registrar's Signature State Registrar

(Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Takona terk

			Please Type or Print in Black In State of Maryland / Dep 1- State Registrar Co		Health and M	lental Hy		_egible.	24943			
3	Physic		Decedent's Name (First, Middle, Last) Belayenesh Egiqu-Begosew			2. Date of Dea Month July 18	ath Day	Year	3. Time of Death 8:25			
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death	July 1		4c. County of Death				
起	Funeral Director	·	2829 Terrace Drive, Apt. 211 5. Social Security Number	Chevy C	If Under 24 Hrs.	8. Date of Birt (Month, Da)	h y, Ye <i>ar</i>)	Cou	otace (State or Foreign			
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location hevv Chas			- 4- 9- 2-		1 Tyes 2 No			
	th with the 23a or 28a	Funeral Director	Maryland Montgomery C 10e. Street and Number 2829 Terrace Drive, Apt. 211		10g. Citiz	en of What Cou	•					
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or items 23a or 28s-f ehow aumatic event, the Medical Exama armust be notified at	by		. Was Decedent of If Yes, specify Cub	20815 Hispanic Origin? (Specian, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Americal Black, White,	can Indian, etc.			
21215-0036	hin 72 ho e. en "netur	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occu re kind of work done DO NOT use retire	during most of worki	ing	16b. Kin	d of Business/In	dustry			
nd 21	be filed wil	Ве Соп		memaker	18. Mother's Name	e (First, Middle,		N Home				
Maryland	should be find Mental he marked of	2	Egigu Begosew			nesh De						
a)	permit. Peges 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny Injury or other traumatic <u>phce.</u>		Mehicret Goberie/Daughter 20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2829 20b. Place of Disposition 2829 20b. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 20c. Place of Disposition 2829 2829 2920 20c. Place of Disposition 2829 20c. Place of Disposition 2829 2829 2920 20c. Place of Disposition 2829 20c. Place of Disposition 2829 20c. Place of Disposition 2829 2920 20c. Place of Disposition 2920 20c. Place of Disposition 20c. Place of Disposi	Terrace position (Name of ematory or other pla	July	211, 26, 27	Chev 20c. Loc	ry Chase	MD 20815 Wen, State Ethiopia			
Ba	Depa Impo eny la		J. Kenyills	500 Univ	ersity Bly	/d, W.,	Silv		ng, MD 2090			
	Physician /Medical Examiner		23a. Parl. Enter the disease, or complications that caused the death. Do not enshow, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	1.	OVAS CUIA	1,	rest, :edSt	2	Approximate Interval Between Onset and Death YEARS			
_	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	that the death certificate led by the attending physic detached for use as the t	Physician/Medic		□Ectopic pregnanc □ Other (specify) _			23	3d. Date of delive Month	ery Day Year			
ecords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the Dementia	underlying cause giv	ven in Part I.	23e. Did to		,	ne cause of death?			
Lec	The law ele has b page 2 s	e Completed	Of Western plants and an advantage of the control o				sy med? 2 X No	24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings available mpletion of cause of 2000			
Vital	Physician: this certific ral director,	0 B	25. Was case referred to medical examiner? 1 Yes 2 No Hospitat 1 Inpatient 2 ER/Outpatie	ent 3 DOA Ot	26. Place of Death her: 4 ☐ Nursing Hor			Other (Specif	ir)			
io uoi	ath. r: After the funeral	ation: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 27 Accident investigation	of 28c. Inju	ry at 2	28d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
DIVISION	To the Hospitel or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (S City or Tow		Number or Rura	ti Route Number,			
	the Hospi nin 24 hour the Funer apletely fill	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my o	opinion, death occurre	ed at the time, o	date and p	olace, and due to	the cause(s)			
)	vith con	M	29b. Signature and title of certifier Attricta Tomsko May, Mo	29c. Licens		-	Julu Julu	signed (Month,	Day, Year) 2007			
			30. Name and address of person who completed cause of death (Item 23a) (Type 14) CIA TOMS KO VAY MD, 1119 K 31. Date filed (Month, Day, Year) 32 degistrar's Signature	ock ville	Pike, 6-100	O, Rock	Kville	e, mD	20852			
	Sta Registr	- 3	IIII 2 0 2007	acts o								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** July 17, 2007 3:26 Fehrer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wicomico Salisbury 1103 S. Schumaker Dr., Apt. 10 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/24/1927 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🗹 F 80 Yrs Washington, DC Director 219-22-7221 Usual Residence of Decedent death with the Manyland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ¥Yes 2 □ No Salisbury Director Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21804 IISA or Itams 23a 1103 S. Schumaker Dr., Apt. 10 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after of Hygiene.

I Hygiene.

other than "natural; or Itan 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry the Medical College (1-4or 5+) Elementary/Secondary (0-12) Environment Activist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fife Department of Health and Mental Hy Importent: If Item 27 is marked oth any jury or other traumatic event pixe. Be Marie Vodacekova Paul Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6717 Ayres Lane, Snow Hill, MD 21863 Melissa Fehrer/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Salisbury Crematory | 7/18/07 Salisbury, MD 4 □ Donation 5 □ Other (Specify) 22, Name and Address of Facility Holloway Funeral Home, Professional Association 21. Signature of Funeral Service Litensee Hell 18 busay 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Neuroendocrine Carcinoma, Metastatic 5 915 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence or, Examiner burial-transit certificate be executed that initiated events ding physicien and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan autopsy 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo Certification: To To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral. 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1 XNatural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50/7/8, 2007 030690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E. Carcoll St., 501,3600 MD MO. Jones E. MA aft, N 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUL 1 9 2007

1	For Stete Registrar	State of Mary		rtificate o	f Health and M of Death	Re	g. No.	07	24945
	. Decedent's Name (First, Middle, Las	st)	-		-	2. Date of Deat Month	n Day	Year	3. Time of Death
an	Leonard Theodore	Flowers				July	17	2007	12:21P ^M
al –	a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of Death		4c. Cour	ty of Death	
C.	Chesapeake Woods	Center			Cambridge		Dor	cheste	r
5	Social Security Number 6 S	ex 7. Age (In	yrs. last birthday)		ear If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthpl	ace (State or Foreign
_	212-10-9181	X M 2□F	98 Yrs.	Months Da	lys Hours Min.	7/31/19	908	Mary	land
1 -	Jsual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10	Od. Inside City Limits
			Combasia	100					1 ☐ Yes 2 🕅 No
7 -	Maryland Dorchest Oe. Street and Number	.er	Cambrio	10f. Zip Coo	de	1	0g. Citizen o	f What Coun	try?
i	5407 Bonnie Brook	Rd.		2:	1613	:	US	A	
ž 1	1. Marital Status		in U.S. 13.	Was Decedent	of Hispanic Origin? (Specular, Mexican, Puerto	ecify Yes or No-		ace - America lack, White, e	
בֿו בֿי	1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No	4	1 ☐ Yes 2 🔀		rticari, otc.)			510.
	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		ı∟ res 2LAL	No Specify:		Spec	whi	te
2	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual O	cupation one during most of work	ing	16b. Kind of	Business/Ind	lustry
pie -	Elementary/Secondary (0-12)	College (1-4or 5+)	1		one during most of work stired)		61 77	c	
Completed	3		Capta	ain/Wat			Shell		
Be C	17. Father's Name (First, Middle, Last,)			18. Mother's Name	e (First, Middle, I	Maiden Sum	ame)	
To B	Charles H. Flower	:s				V. Tyle			
	19a. Informant's Name/Relationship (19b. Maili	ing Address (St	reet and Number or Run	al Route Number	City or Tow	m, State, Zip	Code)
	William G. Sharpe	/Grandson	4711	Steamb	oat Rd., Wo	olford,	MD 21	677	
_	20a. Method of Disposition	2	Ob. Place of Dispo					n - City or To	wn, State
1	1 XBurial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specif				rial Park 7	/21/2007	7 Cam	bridee	MD
	21 Signature of Funeral Service Lices								,
()	Mon a Draza	- 94 mis	4000	Curran-	Bromwell Fu h St.,Cambr	neral Ho	me, P	.А. 3	
X	25a. Part 1. Enter the disease, or com-	polication that caused the	death Do not en	iter the mode of	dving such as cardiac	or respiratory arr	est.	J	Approximate
	shock, or heart failure. List only	one cause on each line.			4	,			Interval Between Onset and Death
1.	Immediate Cause (Final disease or condition		nic car	diony	of ally				geess
	resulting in death)	Due to ur as a co	onsequence of):		1, 1				hears
	Sequentially list conditions.	b. NIKM	0544203	s, gen	enalized				7
nei	S : uential y list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Jue to (or as a co	onsequence of):						
<u>=</u>	that initiated events	c							
	resulting in death) Last	Due to (or as a co	onsequence of):						
cal		d.							
Physician/Medic					3				
2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		□Ectopic pregr	nancy			Date of delive	,
icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		☐ Other (specif				Month	Day Year
hys	9 Unknown	9□ Unknown							
by Pi	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying caus	e given in Part I.				ne cause of death?
	Demontes					X	es 2□No	3 Prob	ably 4 Unknown
iete	Cambrovascula	n accident				24a. Was a		b. Were auto	psy findings available
Completed	Canonin					autop	med?	death?	mpletion of cause of
							≥No No	1 🗆 Yes	2 LJ N0
00	25. Was case referred to medical examiner?	Hospital:	-		26. Place of Dear			241	,
2	1 ☐ Yes ZNo	1 L Inpatient	2 ER/Outpatie			ome 5 Resid			<i>y</i>)
on	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time (Injury at Work?	LOG. DOSCHOU II	CA HIGHLY OC	Julion	
cati	2 Accident investigation			М	1 ☐ Yes 2 ☐ No	006 1 1	Senat 1 A1	mbos as C	Al Pouto Mumber
400	3 Suicide 6 Could not to determined		- At home, farm, s Specify)	treet, factory, o	ffice	28f. Location (S City or Tow	n, State)	moer or Hura	d Route Number,
=									
Certification;		hysician: To the best of n	ny knowledge, dea amination and/or i	ath occurred at tinvestigation, in	he time, date and place, my opinion, death occur	and due to the or red at the time, o	ause(s) and late and pla	manner as s ce, and due to	tated. o the cause(s)
	29a. Certifier Certifying P	MIDEL: Ou the basis of by			,				
edicai	29a. Certifier Check only one) Certifying P 2 Medical Exa	and manner stated	1.						
edicai	(Check only 2 Medical Exa	and manner stated		29c. L	icense number			gned (Month,	Day, rear)
edical	(Check only 2 Medical Exa	and manner stated		29c. L	725935				Day, rear)
Medical	(Check only 2 Medical Exa	and manner stated		29c. L	DZ5935 DZ5935 Laston,				Day, rear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 6:00 A M Arthur Friedman July 2007 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 □ F 78 Director York 096-20-7259 Sept. 15,1928 New Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director 1XYes 2 No Montgomery Gaithersburg MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 Christopher Avenue #11 20879 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ww II 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💢 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Systems Engineer Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Friedman Sara Patlove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Lynne Friedman/Spouse 405 Christopher Avenue #11, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee Name and Address of Facility DeVol Funeral Home Deer Park Drive, Gaithersburg, M 1 RAC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearffailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prostate Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical the SBS the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ned by the stached f 9 Unknown signed by detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performed 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 2 1 ☐ Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural Injury thin 24 hours alter control of the Funeral Director: After the funeral by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, Hospital or Attending To the within 2

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 2 0 2007



30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

mi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Paul Donald 2. Date of Death 3. Time of Death Goetz Jr. Month **Physician** 27 2007 07 2055 PAUL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 20, 1962 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours **X**□ M 2□ F Yrs. МD Director 219-82-3196 45 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Intent of Health and Mental Hyglene. Int: If Item 27 is a marked other than "natural", or items 23a or 28a-f show int: If Item 27 is an marked other than "natural" or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cresaptown Y□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 12914 Sixth Ave. Lot L Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married X ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: white þ п ves, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **Printer** Printing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Donald Goetz, Sr. Carol Mildred (Timbrook) Goetz Hall ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 12914 Sixth Ave. Lot L Cresaptown Sandra Goetz wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/30/2007 Scarpelli Funeral Home, P.A. MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| Probable Drug Overdose Approximate Interval Between Onset and Death Probable Drug Overdose Physician disease or condition resulting in death) 54 cul /Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, CERTIFICAT Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27. Manner of Death Certification: To 2XER/Outpatient 3 □ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Found (Month, Day Year) 5 ☐ Pending investigation Found P Notified 24 hours after death.

To the Funeral Director: Aft Unknown 1 ☐ Yes 2 🛣 No 07/27/2007 8 • 16 3 ☐ Suicide Could not be 28f. Location (Street and Number or Rural Route Number determined 4 Homicide building, etc. (Specify) 12914 Sixth Avenue, Cresaptown Residence To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number Nonsock Shin 200 55 325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrace Frostburg SHIN MD workock 48 Tarn

State Registrar

State of Maryland / Department of Health and Mental Hygiene

1- State Amend #18 per FH 07-24-2007 CN Control of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Thomas Alexander Garrett 2007 7:30 /Medical July 194a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien of Mt. Airy Carrol1 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs 1X M 2 T F Hours Min. **Director** 215-36-4176 82 July 5, 1925 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Carrol1 New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 Old New Windsor Pike USA Funeral 2177612. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2**K** No 1 ☐ Yes 2 🔀 No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4or 5+) 11 self agriculture/dairy fmg. marked other 18. Mother's Name (First, Middle, Maiden Surname)
Anna Braddock Hurley 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill trent of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic even æ မ Thomas Moore Garrett Betty Lou Beane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Old New Windsor Pike, New Windsor, MD Donna Myers, daughter Important: If Item 2, any injury or other it Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Forest Oak Cemetery 7/23/2007 Gaithersburg, Maryland 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service Licens 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or reart failure. List only one cause on each line.

Immediate Come (Final disease or condition resulting in death)

a. — D SHAGE DEMENTIA A(n) 26401 Ridge Road, Damascus, Maryland 20872 **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-1 physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) the 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No autopsy performed' 2 No Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatu 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Records,

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o

Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Voar Carolyn Hope Gates July 9 2007 10:35 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4909 Harrison Ferry Road Hurlock Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X Min. Director 216-40-4807 63 Oct. 16, 1943 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f shov must be notified at MD Dorchester Hurlock Director 1 ☐Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4909 Harrison Ferry Road 21643 IISA Funeral ural", or items? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2X No Specify: þ white 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) assembler electronics 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William T. Todd Ada Ruark ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Gates husband 4909 Harrison Ferry Road, Hurlock, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any Injury or c 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/22/07 Unity Washington Cem. Hurlock, MD 21. Signature # Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) OVAZINN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any the inglet manufacture cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 ☐ Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No. 24a. Was an autopsy performed' certificate the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 No this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No Director; 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WILLIAM JEFFERSON GREY 07/ 2007 8:22PM /Medical 18/ 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7234 Cedartown Road Snow Hill
II Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Worcester Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 214-36-5373 89 3/24/1918 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r than "natural, or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7234 Cedartown Road 21863 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give---Year or Dates: ģ 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer 10 Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ages 1 and 2 should be fill ont of Health and Mental H It If Item 27 is marked out y or other traumatic even Upshur R. Grey, Sr. Minnie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen G. Hagis/ Daughter 8242 Silver Run Ct., Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If eny Injury or once. Whatcoat Cem. 7/21/2007 Snow Hill, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHolloway Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851 san 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebral vascular accident **Physician** /Medical Due to (or as a consequence of): Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Year 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 res 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospita.

within 24 hours effer death.

To the Funeral Director: Affer this c 1 Yes 2 No Certification: To 27. Manner of Death

1 Watural
2 Accident 28a. Date ol Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 🗆 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -MD DS8755 July 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLENN K. ARZADON 9714 HEALTHWAY DRIVE BERLIN, MD ZIBIL BA3 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Eleve & Sperke JUL 2 0 2007 Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar	State of I	Marylan		artment of I		Mental Hy	giene Reg. No.	07	24952
高小	Physicia	_	1. Decedent's Name (First, Middle, Last)	Basia GO	OLDSTE	IN			2. Date of D	Day	2007	3. Time of Death 10:15 P. M
	/Medic Examin		4a. Facility Name (If not institution, give	treet and number	er)		4b. City, Town,	or Location of Dea		4c. Cour	nty of Death)
	, ,		Hebrew Home of Gr				Rockvi				gomer	
	uneral irector		5. Social Security Number 6. Sex 214-47-7606	7. M 2 <u>X</u> F	Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days		n. (Month, D		Cou	place (State or Foreign intry)
70			Usual Residence of Decedent						Sept.	22, 191	4 KOT	
arylan	show	L.	10a. State 10b. County		10c. Cit	y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 📆 No
he M.	28a-f	ecto	Maryland Montgom 10e. Street and Number	ery		N. PO	10f. Zip Code			10g. Citizen o	of What Cou	
with	Sa or	ij	11521 Cherry Grov	o Drive			2087	g		Israel		anny i
death	ms 2;	nera		12. Was Decede Armed Force	ent Ever in U	.S. 13.	Was Decedent of If Yes, specify Cut		(Specify Yes or N		lace - Amer lack, White	
36 after	or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 27	No No	-	1 □ Yes 2∜⊡ No		orto riloan, etc.)		cify: whi	
Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	tural'	Completed by Funeral Director	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Date	95:	16a Dece	dent's Usual Occu	nation		16b. Kind of		
215 hin 72	Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4)	or 5+)	(Give	kind of work done DO NOT use retire	during most of weed)	rorking			,
21. 8d wit	t, he	Com		2		Fash	ion Seam				ion De	esign
pue il pe fil	even	Be	17. Father's Name (First, Middle, Last) Abraham Gerbs						ame (First, Middle		ame)	
Should May	mark	J.	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailii	ng Address (Stree		a Ganzen		vn, State, Zi	ip Code)
Ma nd 2 s	27 is		Anna Kofner, Daugh				1 Cherry					20878
Baltimore,	rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from Sta	20b. F	Place of Disponentery, crea	osition (Name of matory or other pla	ace)	Date	20c. Locatio	n - City or T	Town, State
tim.	tant: I		*4 Donation 5 □ Other (Specify)		Mt		non Ceme		/19/07	Adelph	ıi, MI)
Bal	Department of result and weeting hyperies. Separatively, or items 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Manteal Examinative must be multised at once.		21. Signature of Funeral Service Licens		1	T	2. Name and Addr orchinsk	y Hebrew				
			23a. Part1. Enter the disease, or compli	cations that cau	sed the deat	h. Do not en	54 Carro ter the mode of dy	11 St ing, such as cardi	NW Wash	ington,	, DC	20012 Approximate
Phy	ysician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each	h line.	RIC	NLAF	2 ARI	RYTHI	MIA	,	Interval Between Onset and Death
/M	ledical	i	resulting in death)	Due to (or	as a conseq							VELOC
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760,	hysicien and the burial-transit	Exa	that initiated events resulting in death) Last		as a conseq	uence of):					- 1	
68760, ufficate be e	hysici he bu	lical		l								
N_{i} $B HS IK$ Records, P.O. Box 68	SIS	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No	3c. If yes, outcome 1 ☐ Live birth	n 2∐Feta itattime of d	ildeath 3[Ectopic pregnance Other (specify)	су			Date of delive	very Day Year
P.O	by the	Phys	9 🗆 Unknown	9□ Unknow								4
rds,			Part II. Other significant conditions con	D D	Em t	ENT	1 A	iven in Part I.				the cause of death? bably 4 2 Unknown
ecord	has been s ge 2 should	Completed	HYPOTH	ROII	DIS	M			24a. Wa	s an 24	b. Were aut	topsy findings available ompletion of cause of
	page	Com	OSTEOP	ORO	SIS					omed?	death?	2 🗆 No
of Vital	certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			0	han a	eath (Check only			
P P	r this ral dir	To I	1 Yes 2 No	1 ☐ Inp 28a. Date of I (Month,		ER/Outpatier 28b. Time o	II 3 DOA	4 Mursing	Home 5 ☐ Res	how injury occ		ify)
Vision	ctor: After y the funer	atior	1: Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury		ork?]Yes 2∐No				
\ 5 6	i o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At he , etc. <i>(Specif</i>	ome, farm, st y)	reet, factory, office	1	28f. Location City or To	(Street and Nu own, State)	mber or Rui	ral Route Number,
(FO)	Funeral C	Medical (29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the be ner: On the basi and manner	s of examina	wledge, deat tion and/or in	h occurred at the tovestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
9	To the comple	Me	29b. Signature and title of certifier		ЛА	0	29c. Licer	ise number	200	29d. Date sig	ned (Month	, Day, Year)
05			I three ko	hom	1 14	0	Do	128	4	JUL	- 18	2001
	100		30. Name and address of person who co	mpleted cause	of death (Item	05 (Type,	Print) Pontros	ERD	ROCK	MULE,	MD	20850
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signa	de de	areis					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2007 Youssef 07 15 4:30 Ρ Gholizadeh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery 8909 Bells Mill Road Potomac If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**⊠** M 2□ F Director 83 03/21/1924 219-94-1495 Iran Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ont: If item 27 is marked other than "neturel", or items 23a or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "neturel", or items 23s or 28e-f show other treumstic event, It a Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MDMontgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 8909 Bells Mill Road 20854 Iran Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Banker Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hadji Gholizadeh Fatameh Vanchi ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gholizadeh/Son 8909 Bells Mill Rd, Potomac, Maryland Mahmood 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. National Memorial Pk. 07/18/2007 Falls Church, VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 7482 Lee Hwy. National Funeral Home, Falls Church, VA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 12 Mo. a. Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner 12 Mo. Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physicien: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐ Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cate has been sign, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Chronic Lung Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Cancer of Thyroid certificate has autopsy 1 ☐ Yes 2 🕏 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of Injury filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 X Natural 5 Pending М 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD #00D13292 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hadi Bahar, MD 11500 Old Georgetown Rd, Rockville, MD 20852 31. Date filed (Month, Day, Year)

JUL 2 0 2007 State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar		Marylan	•	artmer rtificat					Reg. No.		25	15
	Physici	an	Decedent's Name (First, Middle,								2. Date of De Month	ath Day	Yeer	3. Time of E	
	/Media		William Percy				1				July	15	2007	10:55	A ^M
	Examir	ier	4a. Fecility Name (If not institution,				,		Location o				unty of Deeth		
			11887 N. Somer: 5. Social Security Number		Age (In yrs.	last hirthday		INCES	s Anı		9 Date of Bis		merset		- Foreign
H	Funeral Director		443-24-2355	1 ∑ M 2□F	79	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da			place (State or ntry)	roreign
D			Usual Residence of Decedent		13						Nov 28	, 1927		OK	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City	/ Limits
	Mar Ba-f si	ţċ	MD Somer:	set	Pr	incess	Anne	€						1 XYes	2 🗌 No
	or 28	ě	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cour	ntry?	
	th wil	Funeral Director	1188 N. Somerset	. Avenue			2	21853				U	SA		
	ems erre	ner	11. Marital Status	12. Was Deced			Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		Race - Americ Black, White,		
9	or It	Ē	1 Never Married 2 Marrie		2 □ No Arm	v	1 ☐ Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ecity: Bla	_	
Ö	within 72 hours after death with the Maryland ene. than "naturel", or Items 23s or 28s-1 show the Madical Examiner coult be mollified at	d by	3 Widowed 4 Divorced	Year or Dat	es:										
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12	within	E G	Elementary/Secondary (0-12)	College (1-	4or 5+)	1110.		siden					[]	_ 2 4	
	Hygie Hygie other ent, tt	ပိ	17. Father's Name (First, Middle, L.	8 ast)			TTCS	ruen		ar's Name	(First, Middle,		Univer:	sity	
an	d be	Be c	Goldman W. Hytch	•							onia Wa				
Maryland	should ind Men ind marke urnetic	2	19a. Informant's Name/Relationshi			19h Mailir	ng Address	(Street a			I Route Numbe		wn State Zin	Codel	
S S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner count by notified at ance.		Deloris J. Hytch								Prince				
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Baltimore,	artme orten injur		21. Signature of Europeal Service Li		Me	morial					2007		took, ()K	
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	Physician /Medical Examiner	ler	shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (o	do		non	ia						Interval Betwo	
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.O. Box	the death certific. y the attending plached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 ☐ Feta nt at time of d	Ideath 3□	Ect <i>o</i> pic pr Oth e r (sp					23d.	Date of delive Month	ery Day Ye	ar .
Records, P	w requires that the de been signed by the should be detached	by	Part II. Other significant condition	s contributing to dea	th but not res		nderlying c	ause give	n in Part I.		23e. Did to		_	ne cause of dea ably 4 ⊟Un	
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Re	fhe law te has age 2 t	E O		V								rmed?	death?	mpletion of cau	use of
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ō	9 Phy er thi		27. Menner of Death	28a. Date of (Month,		28b. Time of		8c. Injury	at		28d. Describe t			Y)	
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Division of	al or Attending s after death. Il Director: After of n by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place o	f Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory	, office			28f. Location (S City or Tox	Street and Nu vn. State)	ımber or Rura	l Route Numbe	B <i>f</i> ,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the bas caminer: On the bas and manne	is of examina	wledge, death tion and/or in	occurred vestigation	at the time , in my op	e, date and inion, deat	d place, a	and due to the e	cause(s) and date and plac	manner as si	ated. the cause(s)	
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	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 0	2007	gistrar's Signa	H A	conti)	7							

Division of Vital Records, P.O. Box 68760, the funeral director. Hospitel or Attending death. hours after death filled in by To the Hosp within 24 ho To the Fune completely fi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PANPLIP. KLUG. 145E Eastoll Street, Salishury. MD. 21804 PANPITP.

29c. License number 29d. Date signed (Month, Day, Year) D0014314 7/18/07

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Medical

4 T Homicide

32. Registrar's Signature

9 2007

determined



Registrar

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200 James Edward Jolley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Rehaba Nursing Ctr Dicomico Salisbun 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 76 Months 1**∑** M 2□ F Director 217-28-3288 Aug. 3, 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State r 28a-f show notified at 10b. County 10d. Inside City Limits 1 XYes 2 No Director MDWicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be or 72 hours after death with or than "natural", or items 23a the Medical Examiner must be 517 Rose Street Completed by Funeral 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within iment of Health and Mental Hygiene ant: If Item 27 Is marked other than "ury or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Wicomico County Maintenance Mechanic Housing Authority 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Linwood Jones Pauline Jolley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Jolley/Wife 517 Rose Street - Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Gardens 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or July 21, 07 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory 22. Name and Address of Facility 1213Jersey Road 21. Signature of Funeral Service Licenses Jolley Memorial Chapel, P.A. - Salisbury, MD 21801 Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Cer 001 /Medical resulting in death) Due to (or as a consequence of): Examiner Les 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Dug to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and to (or as a consequence of): Dug P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the a should be detached 9☐Unknown 9 ☐ Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? l by Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has page perform certificate or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 Tes 2 NO 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To this within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steped. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Jeffries **Physician** Bennie Lee 18, 2007 9:42 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 470 West Dares Beach Road #105 Prince Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 South Carolina 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6 Sex 5. Social Security Number **Funeral** Days Hours 1 □ M 2 X F 213-20-0252 87 Aug 29, 1919 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Prince Frederick Calvert Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20678 U.S.A 470 W. Dares Beach Road 105 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black þ 3 ☐ Widowed 4 ₺ Divorced "naturaf", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) 77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Townsend William Douglas, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 351 Clyde Jones Road Sunderland, MD 20689 Department of Health ar Important: If item 27 Is any Injury or other traconce. Charisse E. Jones /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 07/23/07 Port Republic, MD Ches. Highlands Mem. Gardens 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 Ca Physician 68eaul /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Onknown 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1□ Yes 26. Piace of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 1 Pes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Presidence 6 □Other (Specify) Certification: To After this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 50290 Shel MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 HOSP Dhireu 32. Registra Signature 31. Date filed (Month, Day, Year) State 2007 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Days		B. Date of Birth (Foreig	thplace (State or in
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Director	2461 Cecil Lane 2063	9	τ	J.S.A	
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# B # B #	pr. n.	Alethea Kanios/Mother 2461 Cecil Lar 20a. Method of Disposition 20b. Place of Disposition (Name of cer			20c. Location - City or	Town State
	- 1	1 Burial 2 X Cremation 3 Removal from State crematory or other place)			•	
timent trant:	.	4 Donation 5 Other Specify: Lee Crematory 21. Signature Funeral Service Licensee 22. Name and Address			Clinton,	
Baltimore permit. Pages I Department of F Important: ITi	-	21. Signature / Funeral Service Licensee 22. Name and Address 8125 Souther				
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying,				Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Mixed drug (oxycodone carisoprodol	and Meprobar	mate) into	oxication	Between Onset and Death
aminer		or condition resulting in death) Due to (or as a consequence of):				
	١,	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
ed nsit	Exa	events resulting in death) Last Due to (or as a consequence of):				
executed ian and ial - transit	ical	d. X UNPENDED AMENDED 2 20 5 - ME - 270 - 2/2/07				<u> </u>
50, te be o	ledi	X UNPENDED AMENDED AMENDED AMENDED 23c, 17, 28a-f, perME, g870, 8/3/07 IF FEMALE: 23c, 1f yes, outcome of pregnancy	TT		23d. Date of deliver	
tox 68760, eath certificate be attending physici for use as the buri		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy	,		Day Year
Box (sici	4 Pregnant at time of death 5 Other (Specify)				
that the de ted by the detached is	튑	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
, P.O.	<u>\$</u>			1 Yes	2 🗸 No 3 Pro	pably 4 Unknown
ords, w requir	Completed			24a. Was an		topsy findings available
e law e has ge 2 sl	립			autopsy	ed? death?	completion of cause of
tal Rec		25. Was case referred to medical 26.Place	e of Death (Check only	1 Yes 2 one)	No 1 Y	es 2 No
	e Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursing H	lome 5 Re	esidence 6 Othe	r:
n of \ding Phy.	إيّ	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury		d. Describe hov	w injury occurred	
ttend death. ttor:] atio	Natural 5 Pending Fnd 7/24/2007 Fnd 11:22 am	Yes 2 X No U	ınk		
Division pital or Attenditions after death.	Certification:	3 Suicide 6 X Could not be determined (Specify) Found recidence	ouilding, etc. 28	f. Location (Stre	eet and Number or Ru e) Lane Hunton	ral Route Number, City
E 8 E		4 Homicide (opening) Tourid: Testurate				
DIVI To the Hospital or within 24 hours afte To the Funeral Dir	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion				
To with To com	Me	and manner stated. 29b. Signature and title of gertifigr 29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)
		O.C.I	M.E.		July 25, 2007	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Balt	imore, MD 2120	1		•
Sta	ite	31. Date filed (Month, Day, Year) 32. Repistrar's Signature				

State of Maryland / Department of Health and Mental Hygiene

		State of Marylana /	Certificate of Death	Reg. No.	2007 24959
	Discontinuo	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physiciar Medica	MARIORIA IIIMON KINN		Month Day July 16	2007 6:15 PM
	Examine	4. = 20 41 44 11 11 11 1	4b. City, Town, or		County of Death
		Sacred Heart Home	Hyatts	ville Pr	rince George's
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		Birthplace (State or Foreign Country)
П	Director	273-12-6623 1□ M 2፟ 86	Yrs. World's Days Hours Mill	March 17,19	
	P .	Usual Residence of Decedent			
	enyle		wn or Location		10d. Inside City Limits
	Ne M	D.C. Wash	nington, D.C.		1 ☐ Yes 2 ☒ No
	or 28e-f	10e. Street and Number	10f. Zip Code	10g. Citiz	en of What Country?
	ath v	700 7th Street, SW, Apt #703	20024		S.A.
20	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "naturel", or teme 23e or 28e-f show any jnjury or other traumatic event, the Medical Examinar must be notified at once. To Re Commission by Elizaration Diseases.		13. Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:		4. Race - American Indian, Black, White, etc. Specify: White
Ş	hour lurel	3 ☑ Widowed 4 □ Divorced Year or Dates:			
7	uld be filed within 72 ho Mental Hygiene. arked other than "nature atic event, the Medical E	15. Decedent's Education 16a (Specify only highest grade completed)	 Decedent's Usuel Occupation (Give kind of work done during most of wo life. DO NOT use retired) 	rking 16b. Kin	nd of Business/Industry
12	within	Elementary/Secondary (0-12) College (1-4or 5+)			Correment
0	Hygient Hygien	1 Year	Executive Secretary	me (First, Middle, Maiden S	Government
an	s marked of sumatic eve	Harry Junod			ournamej
2	d Me mark mati			Cone	- O. T. O
Z	d 2 s T is trau	7 17 0 77	b. Mailing Address (Street and Number or R		
Baltimore, Maryland 21215-0020	Heal	I 20a. Method of Disposition 20b. Place of	307 Collingwood Term of Disposition (Name of	ace, Silver	Spring, MD 20904 cation - City or Town, State
<u></u>	nt of nt of street	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	ary, crematory or other place)	07/19	ation * City of Town, State
≣	rtant njury			2007 Bren	twood, Maryland
Ba	Dependent of the poor of the p	21. Signature of Funeral Service Li see	22. Name and Address of Facility HINES-RINALDT FUNE	RAL HOME, INC	C
_	40.200	Nancy A. Vancer Ve	11800 New Hampshir	e Ave.Silver	Spring. MD 20904
	Physician	23a. Part1. Enter the dilease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition resulting in death) a. Multi Organ Fa	11		Months
	Examiner	resulting in death)	consequence of):		
	ficete be executed) physician and ss the bunel-trensit edical Examiner	b. Pra Nuclear E	Bulhar Paley		Vocas
	orute ind trens		consequence of):		Years
Š	e exe	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			
68760	hysic the b		consequence of):		
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õ n	th ce tend or us	d			
- -	he ed for selections of the ed for selections of the selections of	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23b. Did tobacco u	se contribute to the cause of death?
7	let the death control of the ettend leteched for us. Physician/	Ostas Amtheitic		1 ☐ Yes 2 🔀	No 3 Probably 4 Unknown
ń	es the igner be d	Osteo Arthritis			
Bcord	The law requires that the death certificate be executed set has been signed by the ettending physician and page 2 should be deteched for use as the bunial-trensit Completed by Physician/Medical Examir			24a. Was en autops performed?	y 24b. Were autopsy findings available prior to completion of cause of death?
ב	stcten: The law s certificete hes t director, page 2 s o Be Compl			1 □ Yes 2 😿	No 1 ☐ Yes 2 ☐ No
	entifice ector, p	25. Was case referred to medical	26. Plece of Dea	th (Check only one)	
>	Physician: this certific ral director,	examiner? 1 ☐ Yes 2⊠ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Other	ome 5 Residence 6	Other (Specify)
lo uoi	oth. sth. :: After the funeral	27. Manner of Death 28a. Date of Injury 28b. 1	Fime of njury M 28c. Injury at Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury	
	tal or Attending P rs efter deeth. al Director: After t led in by the funera Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	To the Hospital or Attending Physic within 24 hours effect death. To the Funeral Director: After this ce completely filled in by the funeral dire Medical Certification; To In Medical Certification; To In Inc.	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and and manner stated and manner stated.	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	and due to the cause(s) a	nd manner as stated.
	Mec Mec	29b. Signature and title of certifier	29c. License number		
	F ≯ F 8		D19609.		signed (Month, Day, Year)
	0			July	16, 2007
	V -	30. Name and address of perion who completed case of death (Item 23a) (Raman R. Tuli, MD, 10810 Darnes To	• • •	orebure M	20878
			Jwn Road, #202, Gall	rerangra, un	20070
	State Registrar	KKK 9F O 2007	Logate a		

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#19b, perFH, G870, 8/3/07, WS
State of Maryland / Department of Health and Mental Hygiene 1- State Registra AMEND#19bper FH7/20/07, EW, Moo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Mary L. Kiplinger 2007 11:35 P July 15, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 16801 River Road Poolesville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) Days 1 ☐ M 2 💢 F Yrs 356-18-4169 March 14, 1919 88 New York Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1X Yes 2 No Director Maryland Montgomery Poolesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 2 ner must be n 16801 River Road 20837 United States death v Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. r than "natural", or Item the Medical Exa⊞lner 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 is marked o Evelyn Pierpont Daphne Knight 2 Cobb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (I) Md 208377 16801 River Road Poolesville, Austin H. Kiplinger / Husband other t If item or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1¥ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Kiplinger's family Cem. 7/21/07 Poolesville, Maryland
22. Name and Address of Facility Joseph Gawler's Sons Inc. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that auxed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate
Interval Between
Onset and Death
Months Immediate Cause (Final Ovarian Carcinoma, Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending | for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9☐Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy perform 2K No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2N No 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD D0034742 July 16, 2007

State

31. Date filed (Month, Day, Year) JUL 2 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

			rieas	State of M								Legible.	
			For State	State of W	iai ylailu /		rtificate			wientai in	Reg. No.	007	24961
			Registrar 1. Decedent's Name (First, Middle,	Last)				0, 0		2. Date of D	eath		3. Time of Death
	nysicia Medic		Robert O. Logar	ı						July	Day	2007	18:45p ^M
	xamin		4a. Facility Name (If not institution,	give street and number	•)		, ,		ocation of Dear	th	4c.	County of Dea	th
			Catered Living			L ! 1	Ber		f Under 24 Hrs			Vorcest	
	neral ector		186-16-3592	5. Sex 7. A 1 2 M 2 □ F	ge (In yrs. last	Yrs.	If Under Months		Hours Min.		3, Year)	22 Per	thplace (State or Foreign ountry) nnsylvania
land	-	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	ocation				-		10d. Inside City Limits
	fled	ţ	Maryland Worces	ter	0cear	ı Piı	nes						1 ☐ Yes 2X☐ No
th the	Total Total	irec	10e. Street and Number				10f. Zip	Code			10g. Citiz	zen of What Co	ountry?
ath wi	dian	raiD	1135 Ocean Park	way				1811				USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hydinen.	Olner m	Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12. Was Deceden Armed Forces d 1 Yes 2 If Yes, Give	? _{]No} Years	- 1	Was Deced If Yes, spec 1 ☐ Yes 2		anic Origin? (§ Mexican, Puer <i>Specify:</i>	Specify Yes or N to Rican, etc.)		14. Race - Ame Black, White Specify:	
hours af	Exa	d by	3X Widowed 4 □ Divorced	Year or Dates	Unknow	n							
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d within	Te P	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	Me	chani	С			Pape	er Manu	facturing
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Via Duld t	atic	2	Alfred Logan							sie Mae			
Mar 12 sh nand mar			19a. Informant's Name/Relationshi					•		ural Route Num			Zip Code)
C, I	th tr		Donna Hickey/Dau 20a, Method of Disposition	ighter	20b. Place	of Dispo	osition (Nam	e of	, Ocean	n Pines,		21811 cation - City or	Town, State
ages int of	0 10 1		1 ☑Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		e ceme	tery, cre	matory or of ral Cen	her place)	7/2/	/2007			ennsylavania
DESIGNATION Sermit. Pages Depertment of	in in		21. Signature of Funeral Service Li		1	2	2. Name an	d Address	of Facility				
	£ 8	1	eleaner 1	FELL	w	Í	66 Ma	in St	reet,	ne t Pne (Mari	ket, MD	21631
Exam	dical niner	er	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentiary list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	a. Me for a Due to (or a	s a consequence	かこ ce of):	COL	ore o	ctal	COAC	errest,		Approximate Interval Between Onset and Death
cate be executed	the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequenc	ce of):							
the death certification the attending only	should be deteched for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							2	23d. Date of delivery Month Day Year	
Ords, 7.0 requires that the	tep eq pin	Ď	Part II. Other significant condition	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow		
RECORD The law requir	age 2 sho	Completed								per	opsy formed?	prior to death?	utopsy findings available completion of cause of
	tor, p	0	25. Was case referred to medical					2	6. Place of De	1 ☐ Yes ath (Check only		1 10	2010
N V hysic	direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	tient 2 ER/	Outpatie	nt 3 DO			Home 5 ☐ Res	sidence 6	S □Other (Spe	ecify)
JOH O Iding Pt Iff. Affects	e funera		27. Manne of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 4 Injury 4 Work? 2 Accident investigation M 1 Yes 2							28d. Describe	how injur	y occurred	
UNIVISION OI VIIAI MEG To the Hospital or Attending Physician: The lav within 24 bours alter death.	d in by th	Certification	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of I	njury - At home, etc. (Specify)	, farm, st	reet, factory	, office			(Street and own, State,		ural Route Number,
Hospita 24 hours	stely filler	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis and manner:	of examination	dge, deel and/or in	h accurred avestigation,	it tha time in my opin	date and plan ion, death occ	a, and due to the urred at the time	nausa(s) , date and	and marner a place, and due	s statud e to the cause(s)
To the	сомрі	Σ	29b. Signature and title of certifier	1 1 1		1,1		License n		95		e signed (Moni	•
			30. Name and address of person w	to completed cause of	death ritem 23	a) (Type,	Print) 3	3195	Ligh	Thouse	Roc	ad, 5	viteb
R	Sta egistr	te	31. Date filed (Month, Day, Year)	0 2007 32. Re	trar's Signature	* 4	bod	9					9 310

DHMH 17 Rev 1/2001

Robert O. Logan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death DIGE 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 11, [₽]∂07 Walter Lank 11:05 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Casey House Hospice Montgomery Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours Months 1.☐M 2□F 76 193-22-9815 Oct. 28, 1930 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13923 Castle Boulevard #11 20904 United States
14. Race - America Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an Indian 11. Marital Status Black. White, etc. 1 √Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No Korean 1 ☐ Yes 2 ☐ No Specify Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Painter Home Improvement Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Todd- Step-son 326 Winslow Road, Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7-23-2007 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD Fort Lincoln Crematory 22. Name and Address of Facility Simple Tribute, 1040 Rockville 21. Signature of Funeral Service License Unsch, Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of): Parkinson's Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 linknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Hunknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Kother (Specify) 2[No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signatur D006465

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 signed by t page 2 should the Hospital or Attending Physician: director, 24 hours after death e Funeral Director: filled in by the within 24 hou

To the Fune
completely fi

2

Funeral

Director

28a-f show at

death with the

notified

d other than "natural", or Items 23a or event, the Medical Examiner must be

and 2 should be filed within 72 hours after eath and Mental Hygiene. n 27 is marked other than "natural", or ite

permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any Injury or other trau
once.

Physician

/Medical

Examiner

and burial-tran

attending physician for use as the buria

the nse

Saltimore, Maryland 21215-0036

State Registrar

20

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7/11/2007

State of Maryland / Department of Health and Mental Hygiene UU 1 - Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 18 (2007 0135 JULY BESSIE MARGARET LANE /Medical CANEL 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner SPRING SANDY MONTGOMERY BROOKEGROUE REHABILITATION AND NURSING Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 3 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🔀 F 92 Director 464-09-9958 July Missouri Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Laytonsville Md. 1 ☐ Yes 2 X No Montgomery Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6104 Golf Estates Court 20882 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Administration Electronics 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental marked Minerva Dawson Εđ Carner ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Sue Stephenson/Daughter 6104 Golf Estates Court, Laytonsville, Md. 20882 Health Item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Department important: If any injury or once. Metropolitan Crem. 7/18/07 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home muriel Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician BACTERIAL PNEUMONIA 3 WEBKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of) .O. Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by ADVANCED SENILE DEMENTIA 1 ☐ Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificete has l irector, page 2 s perform 1 Yes 2**X** No of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation death. i Diractor: A d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MATERIAN DY 2046 July 18, 2007
who completed cause of death (Item 23a) (Type, Print)
HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MAYLAND 20860 Mun ATTENDINGPAYSICIAN of person who completed cause of death (Item 23a) (Type, Print) GRACE BROOKE 31. Date filed (Month, Day, Year) State JUL 2 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 125 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Reginal 5. Social Security Number 6. Salisburg Center Medical Wesmico Birthplace (State or Foreign Country) last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 2 🗆 F Hours 1 X M Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Funeral Director 1Cr 0 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number . Was Decedent Ever in U.S Armed Forces? 4. Race . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 "natural", or Yes, Give 'ear or Dates: 1 ☐ Yes 2 🗖 No þ Specify: 3 ₩Widowed 4 Divorced K lac or than "natura the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. men" 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ndsey Murra OAL Koal Md. 20b. Place of Disposition (Na cemetery, crematory or 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Rémoval from State 4 Donation 5 Dother (Specify) Signature of Funeral Service License 22. Name and Address of Facility 917 Zabolla Stroot Salisbury, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner tes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine PC St physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after uca...

To the Funeral Director: After in the Funeral Director of the funeral pile in by the funeral pile in the funeral pil

State

Registrar

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(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1008 St. SAlisbury Md Mi VARADARA

31. Date filed (Month, Day, Year)

32. Begistrar's Signature

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	Physici /Medic		Decedent's Name (First, Middle, PAUL HOPE MERI								2. Date of Dea 0 707th 8		7 Year	3. Time of Death 10:55P _M
1	Examin		4a. Facility Name (If not institution, 114 Clarke Ave		ber)				Location o	Death	MD		. County of Deat orcest	
	Funeral Director		5. Social Security Number 714-18-3573	Sex 2□F	. Age (<i>In yr</i> s. 86	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours		3. Date of Birt (Month Da) 09708	h / 1°9		hplace (State or Foreign untry) yland
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20	n 72 hours after death with the Maryland "natural", or flems 23e or 28e-f show edical Evantier must be inclified at	by Funera	11. Marital Status 1 □ Never Married 2 □ Marrie	If Yes, Give	es? "4 2 □ No "4	4 –	Vas Dece Yes, spe	cify Cuba	spanic Ori n, Mexican Specify:	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
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yıaı	thould be id Mental marked o matic eve	To B	William Henry 19a. Informant's Name/Relationshi			19h Mailio	a Addres	1			ane He		or Town, State,	Zin Codel
iore, ma	1 and 2 s Health an em 27 is ther trau		John Merrill/ 20a. Method of Disposition NE Purial 2 □ Cremation 3	Son □Removal from Si	1210		Cresition (Na	eks me of other plac	End	Roa	d, Glo	0UC 20c. L	ester, ocation - City or	VA 23061
Dailillio	permit. Pages Department of I Important: If It any Injury or o		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Fune all Service Li	censee		22	. Name a	nd Addres	s of Facilit	y Hol	loway	Fu	neral	Home P A
			23a. Part1. Enter the disease, or conshock, or heart lailure. List of Immediate Cause (Final	Dean omplications that can hely one cause on ear	used the deat ch line.	th. Do not ente	3 Li	nde:	n Av	e cardiac or	Pocomerespiratory ar	oke rest,	City,	MD 21851 Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to 6	r as a consec	quence of):	1-0-	lung g	J.14	Div	H C	andr	mysmell	lear
200	ped lisit	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a consec	quence of):	,) ear	P						Year
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ב ב	or Attending Physician: The law requires that the that death. Diffector: After this certificete has been signed by the in by the tuneral director, page 2 should be detached.	Completed										an sy rmed! 2 No	prior to death?	utopsy findings available completion of cause of
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SION OF	nding Phi ath. r: After thi e tuneral	atlon: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of (Month)		28b. Time of Injury		28c. Injun		28	3d. Describe h			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely tilled in by the tun	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place C	ol Injury - At h g, etc. <i>(Speci</i>	ome, farm, stre fy)	eet, lactor	y, office		28	8f. Location (5 City or Tov			ural Route Number,
	e Hosp 124 hou e Fune letely til	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the beaminer: On the bas and manner	sis of examina	owledge, death ation and/or inv	occurred	at the time n, in my of	ne, date an pinion, dea	d place, ar th occurred	nd due to the	cause(s date an) and manner as d place, and due	s stated. e to the cause(s)
1	To the To the comp	ž	29b. Signature and title of certifier					c. License					ate signed (Mont	
	0 6 1		30. Name and address * person w	no completed cause	of death (Iter	m 23a) (Type,	Print)		<i>y</i> -0	700	\$,	1.6	1. 21804
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DHMH 17 Rev 1/2001

07-05818 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Joseph McDonnell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day July 29, 2007 Medical Examiner William Joseph McDonnell 2013 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2308 Eccleston Street Silver Spring Montgomery **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign Country) Maryland Months Days Hours Director 213-92-0516 Min 43 1X M 2 Aug. 9, 1963 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No or items 23a or 28a-f sho must be notified at once. Maryland Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2308 Eccleston Street 20902 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, 1 X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married Yes 2 Pages 1 and 2 should be filed within 72 hours after trnent of Health and Mental flygener rautt. If iten 27 is marked other than "natural", o y or other traumatic event, the Medical Examiner. If Yes, Give Year 1983-85 Divorced 1 Yes 2_X No specify: SpecifWhite by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Landscaper Lawn Maintenance 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William McDonnell <u>Nancy Pellek</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy McDonnell/ Mother 3350 Chiswick Court, #571A, Silver Spring. Baltimore, | permit Pages 1 and Department of Inter-Important: If iter-iniury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 July Metropolitan Crematory 2007 Donation 5 Other Specify Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 500 University ns Funeral Home Blvd, W., Silver Inc. Spring, MD 2090 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Cocaine and methadone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): X UNPENDED perME. 2870

The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial - tran P.O. Box 68760, of Vital Records, this certificate has been if director, page 2 should

After

within 24 hours after death To the Funeral Director:

Division

Physician/Medical IF FEMALE: 23b. Was decedent pregr past 12 months? Yes 2 No 9 Part II. Other significant þ Completed 25. Was case referred to Be 1 V Yes 27. Manner of Death Natural in by the Accident 3 Suicide

Homicide

29b. Signature and title of certifi

Jack Titus MD.

29a. Certifier (Check only 1 one) 2

Medical

State Registrar

uant in the	1 Live birth 2 Fetal death 3 Ectopic pregnated Pregnant at time of death 5 Other (Specify) 9 Unknown	ancy Month Day Year
conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
medical	26.Place of Death (Check	only one)
No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin	ng Home 5 Residence 6 🗸 Other: Scene
Pending Investigat X Could not determine	be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28d. Describe how injury occurred unk 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2300 Foc1eston St., Silver, Spring M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

and manner stated

Deputy Chief Medical Examiner

strar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

July 30, 2007

MD 20906

Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ju Month 17, 4:05 P M Fanya OKUN 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Maynth 9Day, 1928 Berarus 216-37-8100 1 ☐ M. 2 👿 F 79 Yrs Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director MD Rockville 1 D Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 95 Dawson Ave. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 21 No Specify. White ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Soviet Union Dept. of Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Economist permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important; If Item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rebecca Plotkin Aaron Okun ည 19a. Informant's Name/Relationship (Type. Print) Alan Revzin / son 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State 70 900) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lebanon Cemetery July 20, 2007 Adelphi, MD 21. Signature of Funeral Service Vicense 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 CArroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sudden Cardiac Death /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit and Due to (or as a consequence of): physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρį in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760. Division or Vital Records, Hospital or Attending

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Medical

Certification:

29a. Certifier

29b. Signalure

(Check only one)

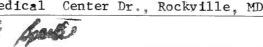
Registra

Manish Gambhir, MD 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 0 2007



1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0061415

29c. License number

29d. Date signed (Month, Day, Year)

July 18, 2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year PARKINSON Physician MYRTLE LOUISE P^{M} 18, 2007 3:25 JULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset Alice Byrd Tawes Nursing Home Crisfield If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours Min 1 ☐ M 2 💢 F Yrs. 90 August 15, 1916 Director Maryland 216-12-1892 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and: If item 27 is marked other than "natural; or Iteme 23a or 28a-1 show thy or other than the modified as try or other traumatic event, the Madical Examine mant be notified as tXYes 2 □ No Director Crisfield Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 USA Completed by Funeral 6 Hudson Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XXo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping Services 9 Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Pestridge 2 Lucious Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 Heron Way - Crisfield, Maryland 21817 James P. Parkinson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H important: if its any injury or ot once. N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/21/2007 Crisfield, Maryland Asbury Cemetery 21. Signature of Funeral Service Linear 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main ST. - Crisfield, MD 21817 Mary Beth Bradshaw-Prui 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): ettending physicien Box 68760 Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 2/2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director: Atter ti Certification; Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 48098 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Hall Highway - Crisfield, MD 21817 M.D. Vijay Karumbunathan, 31. Date filed (Month, Day, Year) State JUL 23 2007 Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State of M	aryland		artmen			and M		giene Reg. No.	007	21,971
	Physici		Decedent's Name (WILLIAM		PERKINS							2. Date of De. Month	ath Day	Year 2007	3. Time of Death 11:40P M
1	/Medio Examin		4a. Facility Name (If n	not institution, gi	ve street and number	r)		4b. Cily,	Town, or	Location o	f Death	JULY		County of Death	
	Funeral Director		HOLY CROS 5. Social Security Num 412-64-6	mber 6.		Age (In yrs. las	st birthday) Yrs.	SI If Under Months	LVER 1 Year Days	SPRI If Under: Hours	NG 24 Hrs. Min.	8. Date of Bin (Month, Da	h y, Year)	าาษาสี่ใ	ERY place (State or Foreign ntry) ESSEE
	pug *		Usual Residence of D	ecedent 10b. County			Town or Lo	cation				- JOHI -	., .,		10d. Inside City Limits
	Maryla -f eho	tor		MONTGOM	ERY		ER SPI								1 Yes 2 No
	death with the Maryland ome 23a or 28a-f ehow if must be notified at	Funeral Director	10e. Street and Numb		IA PIKE #	602		10f. Zip	Code 2090	04			10g. Citiz USA	en of What Cou	ntry?
36	o 72 hours after death with the Marylan "naturel", or Iteme 23a or 28a-f ehow selical Examilian mast ke notified at	by Funer	11. Marital Status 1 Never Married		12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give	s? No X		Was Deced If Yes, spec	rty Cubar	spanic Origin, Mexican Specify:	gin? (Spe , Puerto i	cify Yes or No Rican, etc.)	ļ	4. Race - Ameri Black, White Specify: RT	
21215-0036	72 hours naturel'	ted b	3 Widowed 4	5. Decedent's f	Year or Dates Education		16a. Dece	dent's Usua	I Occupa	tion			16b. Kin	d of Business/Ir	
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Maryland		To Be	ALBERT PE	RKINS							MARY	ELLEN	EVAN	S	
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	1 an Heal Heal Em 2 ther		ALBERT TR 20a. Method of Dispo	sition			ce of Dispo	sition (Nan	ne of			CLINTON ate		20/35 ation - City or T	own, State
E O			1 X Burial 2 ☐ 4 ☐ Donation 5		□Removal from Stat	Θ .	netery, crer VETEI	-			III.Y	25. 200	7 CH	ELTENHA	M. MARYLAND
Baltimore,	permit. Page Depertment of Important: If eny Injury or		21. Signature of Fund	eral Servi el ico	ensie	la	22	2. Name an	d Addres	s of Facilit	HIN:	ES-RINA	LDI	FUNERAL	HOME, INC.
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	Examiner	-	Sequentially list rond if any, leading to imm	ditions		ENTRICU		ARRYTI	MIA						
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,092	ite be executed sysicien and ne burial-transit	cai Exa	resulting in death) La	st	Due to (or a	is a conseque	nce of):						,		
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<u>α</u>	uires thet signed by Id be deta	ρ	Part II. Other signific		contributing to death			nderlying c	ause give	n in Part I.					the cause of death?
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ion	Attending Ph r death. ctor; After th by the funeral	ation	1 X Natural 2 ☐ Accident	5 Pending investigati	28a. Date of In (Month, I	Day Year)	Injury	м	8c. Injury Work 1 🗀 Y	? /es 2 🗍					
Division	al or Attens s efter deat of Director; ed in by the	Certification:	3 Suicide 4 Homicide	6 Could not determine	d 200. Place of I	njury - At hom etc. (Specify)	ne, farm, str	eet, factory	, office		•	28f. Location (City or To		l Number or Rui	al Route Number,
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 (Check only 2 one)	Certifying F Medical Exa	Physician: To the be- aminer: On the basis and manner	st of my knowl of examination stated.	ledge, deat on and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the To the complet	¥	29b. Signature and tit	tle of certifier	0-	^ ~		290	. License		0			signed (Month	, Day, Year)
	5		30. Name and address	ss of person wh	o completed cause of	f death (Item 2		Print)	טטע	06410			0//16	6/2007	
_			SMITHA BH		M D 1500	FOREST	GLEN	·	SII	VER	SPRI	NG, MD	20910)	
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DHMH 17 Rev 1/2001

				For State Registrar		State o	t Marylar		artment of ertificate of	Health and Death	Mental Hy	/giene Reg. No.)	ñ 7	0107)
		Physici		Decedent's Name (Fire Day		PASS					2. Date of De July	eath 2007	Year	3: Time of Death 3:41 PM M
		/Medio		4a. Facility Name (If not i	institution, give	e street and nui			4b. City, Town, Beth	or Location of Deat		4c. Coun	ty of Death	
		Funeral Director		5. Social Security Number 001 -28 -992 9		ex	7. Age (In yrs.	. last birthday Yrs.) If Under 1 Yea Months Days		8. Date of Bi	irth 14 ^{Yea} 1938	9. Birth	place (State or Foreign
		/land ow at		Usual Residence of Dece 10a. State 10b.	edent county		10c. Ci	ity, Town or L	ocation					10d. Inside City Limits
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		th with the 23a or 2 st be no	Funeral Director	109. Street and Number 10304 Lorai					10f. Zip Code 2090	02		10g. Citizen of	What Cou	ntry?
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any filury or other traumatic event, the Medical Examiner must be notified at once.	y Funer	11. Marital Status 1 Never Married		Armed Fo 1 ☐ Yes If Yes, Giv	2 No	J.S. 13	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer Specify:	pecify Yes or Note Rican, etc.)		ace - Americack, White,	etc.
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	nd 2	al Hygid I other	Be Co	17. Father's Name (First,					4-3 +	18. Mother's Nar		e, Maiden Surna	<u>.</u>	
	ıryla	should bed marked marked marked	To	Henry 19a. Informant's Name/F	Pass	Type, Print)		19h Maii	ing Address (Stree	Jud et and Number or Re		Pier	State Zir	o Code)
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	nore	ages 1 ent of H t: If iten y or oth		20a. Method of Disposition 1 Burial 2 Cre 4 Donation 5 D	emation 3 🗌		State Mt.	Place of Disp cemetery, cre Leban	osition (Name of ematory or other pl on Cemet		Date 200	20c. Location 7 Adelp	•	
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	ion or	Ilng Ph I. After th funeral	$\vdash $	27. Manner of Death	☐Pending investigation	28a. Date (Moni		28b. Time Injury	of 28c. Inju			how injury occu		<u>y)</u>
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		- W		30. Name and address of MOLISSIT L	f person who	completed caus	e of death (Iter	n 23a) (Type (00000	Print) Print)	LD SIBL	RBANH	KOSPITAL	- Re	MUSCA MI)
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			For State Registrar	State of	f Maryland		artment rtificate			and M		jiene	0.07	01.070
	Q		Decedent's Name (First, Middle, L.	ast)							2. Date of Dea	th		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, ga				4b. City,	Town, or	Location o		oury ro	1	County of Death	
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	Funeral		Social Security Number 6.		7. Age (In yrs. las	t birthday)	If Under Months		If Under		8. Date of Birth (Month, Day	Vear	9. Birth	place (State or Foreign intry)
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	pug &		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	nation							10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinatings to cliffed at	Funeral	11413 Hodson Whi		dent Ever in U.S.	13.		2182		gin? (Spe	cify Yes or No-		USA 14. Race - Ameri	ican Indian
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Maryiand	12 sh h and 7 Is n		19a. Informant's Name/Relationship Sandra Lee Rietz				-						Town, State, Zi	ip Code) MD 21821
_	1 and Health sm 27 ther tr		20a. Method of Disposition	TOW/WITE	20h Plan		sition (Nam		WIIILE		ate Danie		cation - City or T	
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Baltimore,			' 4 ☐ Donation 5 ☐ Other (Spec		Bozi						0/2007	Dame	es Quart	er, MD
n n	permit. Departi Import any inj		ANON IVI	1 WAI	M00297		inman							
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that c	\	Do not ent	16/3 ter the mode	Some:	rset z. such as	Ave.	, Princ	ess.	Anne, M	D 21853 Approximate
	Dhusisian	1	shock, or heart failure. List onl Immediate Cause (Final	y one cause off e							,			Interval Between Onset and Death
	Physician /Medical	-	disease or condition resulting in death)	a	Prostat	nce of):	merr							1 years
	Examiner				uo u ooooquo.									
	الجبيب	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a conseque	nce of):								
	cuted nd ransii	Examiner	that initiated events	С										
Ď,	a exe ian ai ırial-t	E	resulting in death) Last	Due to (or as a consequer	nce of):								
8/PU	the death certificate be executed y the attending physician and tched for use as the burial-transit	dicai	•	d										
٥	eath certific attending pi	Mec	IF FEMALE:											
gog	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnanc irth 2 Fetel de	eath 3	⊒Ectopic pre					2	23d. Date of delive Month	very Day Year
	at the de by the a tached f	Physician/Me	1 Yes 2 No	4∐Pregn 9☐Unkno	ant at time of deat own	th 5	Other (spe	ecify)					1913/111	Du) rou.
Į.	that the	Ph	Part II. Other significant conditions	contributing to de	ath but not resulti	ng in the u	nderlying ca	ausa nive	n in Part I		23e. Did to	bacco u	se contribute to	the cause of death?
as,	law requires Ihat as been signed b 2 should be deta	d by	Commay a	vtern	difesse		,	3			1□Y			babiy 4 🗆 Unknown
Hecords	v req been shou	ete	Consesso	heart of	1						24a. Was a			
ě	0 5 0	Completed	Congestive	war o	acian						autop	sy	prior to co	opsy findings available ompletion of cause of
Vital	iclan: Th certificate rector, pag	e Cc	25. Was case referred to medical	1						15		242 No	1 🗆 Yes	2□ No
		0 8	examiner? 1 ☐ Yes 2⊠No	Hospital:	npatient 2 EF	VOutpatier	nt 3□ DO	Δ Othe	-		(Check only or		3 ☐Other (Speci	26.1
0	g Phys er this eral di	-	27. Manner of Death	,		8b. Time o		Bc. Injury	at		8d. Describe h			197
0	Attending in death. ector: After by the fune	atio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigati		n, Day real)	Injury	М	Work 1 🗆 Y	/ ′es 2 🗆 l	No				
DIVISION	r Atte er de recto	Certification;	3 Suicide 6 Could not determine	200. Place	of Injury - At hom-	e, farm, sti	eet, factory	, office		2	8f. Location (S City or Tow			ral Route Number,
	Ital o Irs aft rel Di	Cer			, , , , , , , , , , , , , , , , , , , ,									
	To the Hospitel or Attending F within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical Ext	iminer: On the ba	best of my knowle sis of examination	edge, deat n and/or in	h occurred a	at the tim	e, date and	d place, a th occurre	nd due to the o	ause(s) late and	and manner as	stated. to the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manr	ner stated.		1.00							
	T W T 8		brM/				7	000	392	.04	-	7	e signed (Month,	, way, rear
			30. Name and ad less of person who	completed caus	e of death (Item 2	3a) (Tyne	Print)			,		- 1	1-101	
0 4	I EB		Benn			45	Carn	110	St.	, Sa	ilisbur	y, M	2/20/07	r01
	Sta	- 1	31. Date filed (Month, Day, Year)	32. R	egetrar's Signatur	ГӨ Д		-		,		(
	Registr	ar	JUL 2 4	2007	alexan	18 .	Board							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** Month 8:50 PM Shaun Joseph Rowley 2007 July 10. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F Director 0 2 48 Maryland None July 10, 2007 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 Maple Avenue 20851 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Unknown other traumatic ဥ Doni Leslie Rowley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau Doni Leslie Rowley / Mother 1008 Maple Avenue, Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 7/19/2007 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or treat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or por dition resulting in death) REMATURIT **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy 1☐ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. Director; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aft 12Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTER DRIVE, ROCKVILLE, MD 20850 GROSSMAN 9901 MEDICAL DAVID

State Registrar 31. Date filed (Month, Day, Year)

JUL

20

2007

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		rtificate of l		Wentarriy	Reg. No.	07	2 , 9	175
,	Physici	e an	1. Decedent's Name (First, Middle, Last)				2. Date of De		Year	3. Time of	Death
22	/Medi		Jeanne Clare Ridley				July 17		T C C I	10:27	a. M
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County			
2 -			3128 Gracefield Road , Apt. 220 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	lver Sp	S. 8 Date of Bir	Prince			r Fornia
D	uneral irector		043-20-7927 1□ M 2XF 81 Usual Residence of Decedent	Yrs.	Months Days	Hours Mir	. (Month, Da	8, 1925	Pen	place (State ontry) ntry) nsylva	nia
ryland	how			c. City, Town or Lo	ocation					10d. Inside Ci	ty Limits
ne Ma	8a-f s otified	cto		Silver S	pring					1 ☐ Yes	2 X No
with th	be no	Funeral Director	10e. Street and Number	000	10f. Zip Code			10g. Citizen of \		ntry?	
leath	ns 23 must	eral	3128 Gracefield Road, Apt. 11. Marital Status 12. Was Decedent Ever			20904	Specify Ves or No		JSA	can Indian,	
d 21215-0036 filed within 72 hours after death with the Maryland Hyniane	Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Armed Forces? 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2★ No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 為文No	n, Mexican, Puè	rto Rican, etc.)	Blac Specify	ck, White,		
5-0 72 ho	hatur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation Juring most of w	arkina	16b. Kind of Bu	usiness/In	dustry	
Vithin	than "	E I	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired		sining				
filed V	ther i		17. Father's Name (First, Middle, Last)	D	emographe		ame (First, Middle	Educat			
Maryland Id 2 should be file	ked o	To Be	Edward Walter Clare				garet Ca		10)		
ary shou	mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numb	er, City or Town,	State, Zir	Code)	
ore, Massin as 1 and 2	n 27 is er tra		Christy Ridley/ Husband		Gracefiel						904
Sattimore, bermit. Pages 1 ar	nt: If item ry or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		sition (Name of matory or other place tan Crema	·	Date	20c. Location -	-		_
and rmit.	Importa any inju		21. Signature il Funeral Service Licensee		2. Name and Addres		2007	Alexandr 1 Home 1	ia. no	Virgin	ia.
n 86	를 등 등		(instrew Cole		00 Univer					. MD 2	0901
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Bety	e ween
	sician		Immediate Cause (Final disease or condition resulting in death) a. Dementia	3						Onset and E	o 4
	ledical aminer		Due to (or as a cor	sequence of):							
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uted	d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events								
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x sertific	ding p	Mec	IF FEMALE:				_				
The law requires that the death ce	attendir for use	Physician/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 ☐	Ectopic pregnancy			23d. Dat Mo	te of delive		'ear
at the de	y the	ysic	1 ☐ Yes 2 ⊠ No 9 ☐ Unknown 4 ☐ Pregnant at time 9 ☐ Unknown	or death 5	Other (specify)					,	
that	been signed by the should be detached		Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did t	obacco use conti	ribute to th	he cause of d	eath?
daire	an sig	ed by	Interstitial Lung Disease				10	Yes 2 No	3 🗌 Prob	oably 4 □U	Inknown
The law requires t	2 sho	Completed					24a. Was		Nere auto	psy findings a	available
The	page 2 :	mo.					autoj perfo 1□ Yes	ormed?	orior to coi death? I □Yes	mpletion of ca	ause of
VILCII Sician: 1	certificate rector, pag	Be (25. Was case referred to medical examiner?			26. Place of De	ath (Check only c				
hysic	this o	卢	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien		4 LI Nursing I	Home 5 ☒ Resi	dence 6 🗆 Oth	er (Specif	y)	
l or Attending Phys after death.	After	ü	27. Manner of Death 1 □ Manuary S □ Pending 28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Work		28d. Describe I	how injury occurr	ed		
ttend	the f	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - A	At home form etr		'es 2 □ No	001 1				
lorA	Director:	Certification:	4 Homicide determined 200. Place of injury - 7 building, etc. (Sp	ecify)	set, factory, office		City or Tox	Street and Numb vn, State)	er or Hura	u Route Numi	ber,
the Hospital or Attending Physician:	To the Funeral Di		29a. Certifier (Check only only only only only only only only	knowledge, death	n occurred at the tim	e, date and place	e, and due to the urred at the time	cause(s) and ma	nner as s	tated.)
the thin 2	the mple	Medical	one) and manner stated. 29b. Signature and title of certifier								
Į, W	Ĕ [®]	_	AT 1	ahlall	29c. License D23			29d. Date signed Ju		<i>Day, Year)</i> 7 , 200	7
9	>	-	30. Name and address of person who completed cause of death ((Item 232) /Tibe	Print)					····	
			John Stuckey, M.D. 3110 G	racefield	d Road, S:	ilver Sp	oring, MI	20904			
	Sta Registra		31. Date filed (Month, Day, Yeal) 32 Registrar's S		all o						

			For State Registrar	State of Ma	-	partment of F e <i>rtificate of I</i>			g. No.	1	245	15
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2 Date of Death Month July	15, 20	ear N 7	3. Time of 1:10	Death P _M
	/Medic Examin		Jimmy Lee S 4a. Facility Name (If not institution, give	pence street and number)		4b. City. Town, o	r Location of Death	July	4c. County of		1.10	
	Examin	er	10320 Harrison Roa			Berlin			Word		er	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda	2011111	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State of	or Foreign
	Director		216-70-1668	M 2□F	52 Yrs.	World S Days		Jan. 6,			land	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location	,			10	Od. Inside C	ity Limits
	f aho	ō	7.7		D 1							2 XNo
	death with the Maryland ms 23a or 28a-f ahow Imust by Lodiffed at	Director	Maryland Worcester 10e. Street and Number	·	Berli	10f. Zip Code		10	Og. Citizen of Wha	at Coun	try?	
	3a ol		10320 Harrison Roa	d		2181	1		USA			
	deat	Funeral		12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was Decedent of H		ecify Yes or No-	14. Race - Black,			
2-0036	be filed within 72 hours after death with the Marylan ital Hygiene. id other then "neturel", or items 23s or 28s-f show avent, if a Mudical Examinat must be collided at event, if a Mudical Examinating.	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 2K No	Specify:	, , , , ,	Specify:	Blac		
ב ה	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. De	cedent's Usual Occup	ation	100	16b. Kind of Busin	ess/Inc	lustry	
7	ithin ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+) life	DO NOT use retired	1)		Ocean Ci	ty (Golf &	
V	led w lygier har th		12th 17. Father's Name (First, Middle, Last)		Ass	. Superinte		e (First, Middle, M	Cacht Cli	ıb		
and	I be fi	Be		0				e (rirst, Middle, M				
Ξ	2 should be filed and Mental Hygi is marked othar aumatic avent, I	ဋ	Herbert 19a. Informant's Name/Relationship (Ty	Spence	19h M	ailing Address (Street	Ethel	al Route Number	Adkins	ate Zin	Codel	
Z	s 1 and 2 should if Health and Men Itam 27 is marke other traumatic		Hilton Spence/brothe			06 Delawar						045
ē,	f Healthan		20a. Method of Disposition		20b. Place of Dis	sposition (Name of rematory or other place			20c. Location - Cit			7,040
Ē	00		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		UMC Cem	1	21/2007	Berlin, N	larv	land	
Saltimor	permit. Pages Department of Important: If I eny Injury or once.		21. Signa ure if Funeral Service License			22. Name and Addre	ss of Facility 121	3 Jersey	Road, S	alist	oury,	MD
מ	8259		Tarun (1. 124	ey	Jolley Mem	orial Cha	pel, P.A.			218	01
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the cause on each line	he eath. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arre	est,	J.	Approximat Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Mut	4 DU	mes	elom	M		K	2/11	wh
	/Medical Examiner		resulting in dealth)	Due to (or as a	consequence of):						8	
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_	E On es		IF FEMALE:									
o n	death certif e attending id for use a	ician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth 2	Fetal death	3 □Ectopic pregnancy	,		23d. Date of Month			Year
- 5	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at t 9☐ Unknown	ime of death	5 ☐ Other (specify)					,	
7	that the ed by th detache	/ Physi	Part II. Other significant conditions cor	ntributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to th	e cause of	death?
SD	een sign	d by				_		1 □ Ye	s 22 No 31	Prob	ably 4 🗍	Unknown
Cord	law rec as bee 2 shou	ompieted						24a. Was ar	1 24b. We	re autop	sy findings	available
Ď Ľ	0 5 6	omp						autopsy perform	ned? dea	th?	npletion of a 2□ No	ause of
<u>E</u>	certificate	Be C	25. Was case referred to medical				26. Place of Deat	h Check only one		103	20140	
<u>_</u>	Physician: this certific al director,	2	1 105 21 140		t 2□ER/Outpa		4 LI Nursing Ho	ome 5 eside	nce 6 Other	Specify	')	
0	Attending Physicien: or death. ector: After this certific by the funeral director.	ü Ö	27. Man or of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b, Time Injur	y Wor		28d. Describe ho	w injury occurred			
Vision	ttand death ttor: /	icat	Accident investigation 3 Suicide 6 Could not be	20a Diago of faire	n. At home form	M 1 □	Yes 2 □ No	28f. Location (Str	not and Mumber	O	l Courte Alum	a box
<u>≥</u>	spital or Attan ours after deat neral Director: filled in by the	Certification:	4 Homicide determined	building, etc.	(Specify)	street, factory, office		City or Town.	, State)	or mura	rioute ivan	1061,
	6 4 구 9	edical	29a. Certifier Certifying Physical (Check only one)	sician: To the best of ner: On the basis of and manner stat	examination and/o	eath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mann ate and place, and	er as st due to	ated. the cause(s)
ŀ	To tha within 2. To tha to complet	Me	29b. Signature and title of certifier	Vahre)	29a Licens	6 /37	29	ed. Date signed ()	Month,	Day, Year)	
	11/2		30. Name and address it person who co	empleted cause of de	ath (Item 28a) (Ty	Print Inth	11, 111	218	00			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	's Signature	con ou	4/00	1010	1			
	Registr		JUL 2 0 20	07	H	Lack .	1					
						1000						

ORIGINAL

			1 - For State Registrar	State of Marylan		artment of F rtificate of			ene UU7	24977
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	SCHN	AR	TZ		2. Date of Death Month.	Day 2007	3. Time of Death 9:25PM
	Examin		4a. Facility Name (If not institution, give st Hebrew Home of Grea		on	4b. City, Town, o	r Location of Death 11e		4c. County of Deat	
	Funeral Director		5. Social Security Number $181-38-2032$ 6. Sex	м 21XF 7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Nov . 14	Year 1917 New	hplece (State or Foreign untry) York
	Maryland -I show Ilou at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomen	_	y, Town or Lo					10d. Inside City Limils 1 ☐ Yes 2 ☒ No
	3a or 28s	i Directo	10e. Street and Number 6105 Montrose Road			10f. Zip Code 20852			g. Citizen of What Co Jnited Sta	
736	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itams 23e or 28e-f show event, the Medical Examinar most ke natified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: wh	e, etc.
Maryland 21215-0036	within 72 hou ene. than *natura ne Modical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life. Homen		pation during most of work d)	aing 1	6b. Kind of Business Own Home	Industry
land z	should be filed within a Mental Hygiene. Thanked other than martic event, the Memorial counts.	To Be Co	17. Father's Name (First, Middle, Last) Marcus Zausme:	r	1			e (First, Middle, M na (unkno		
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190			30. Name and address of person who David S. Schacht	er, M.I	7525	Greenw		er Dri	ve,#2	212 Gre	enbel	t, Mary	land 20770
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE MARK BOOK FIT G870 88 07 WS ARE LEGIBLE. State of Maryland Department of Health and Mental Hygien 2 0 0 7 24979 1- State Registrar Amend #1,perMD,g871, 9/7/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Irvin -Adelson August 3, 2007 Irving Adelson /Medical 6:30a M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 1 Date of Birth Months Days Hours Min. 12 Min. 12 March 23, 1924 5. Social Security Number 146-16-8841 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1X M 2 ☐ F Director 83 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location in then "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits MD Montgomery Rockville Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 20852 10g. Citizen of What Country? USA 6111 Montrose Road # 407 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 Never Married 2 Married 1X Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3X Widowed 4 ☐ Divorced Specify: White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry I Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Pharmacist Pharmacutica1 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liviry or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Philip Adelson Eva Levine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frona Adelson / Daughter 3439 - B2 South Stafford Street, Arlington, VA 22206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rosenbaum Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) August 6,2007 Hampton, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ZHEIMER'S DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Year 5 Other (specify) Day been signed by the should be detached Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ ADETES MELLITUS - TYPE 2 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENTION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Vital after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 of 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 TYes 2 TNo 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 00018084 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) 0(21 MONTRUSE RD ROCKVILLE MD 20852 32. Regisper's Signature
7 Service & Specific 31. Date filed (Month, Day, Year) State Registrar

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nna Marie Berg		l I- For State Registrar	State	of Maryland		iment of ficate of		ia Menia	ai Hygie	ene Reg.	No.	200	7 249
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 03 Physician LANCHE 200 /Medical 4a. Facility Name (If not institution, give street and number, r Location of Death 4c. County of Death Examiner NI LTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month Day) (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🗷 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director YARYLAND 10e. Street and Number 10g. Citized of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HNAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHA Baltimore, 20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenser art1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death n hediate cause (Final sease or condition esulting in death) **Physician** VNG monters /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): the aftending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mont 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown cate has been signed by to page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performe 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPI 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar

31. Date filed (Month, Day, Year) AUG 0 6 2007

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maries

29c. License number

8303

29d. Date signed (Month, Day, Year)

07-05900	
Carl Eugene Barnes	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar			(Certifica	ate of I	Death					Reg. No.			
Physicia		Decedent's Name (First, Middle)	e,Last)									Date of De		Year		Time of Death
ledical Examir		Carl Eugene	Bar	nes							/	Month August 1	Day , 2007	Teal		2325 hrs
		4a. Facility Name (if not institution	n, give str	eet and nu	mber)		4b	. City, To	wn, or Lo	cation of	Death		4c. C	County of	Death	
		2400 Westwood Ave					- 1	Baltimo	ore							
Europel	-	5 Social Security Number	6. Sex		7. Age (In	yrs. last birth	nday)	If Under	1 Year	If Under	24Hrs. 8	B. Date of B	irth(MM/DI	D/YYYY)	9. Birthpl	ace (State or
Funeral Director		5. Social Security Name						Months		Hours	Min.		1-19	I F	oreign Counti	
Director	Ľ	210-27-11 4	1 X M	2 F		35	Yrs.					0/-1	1-19	12		y) MD
	_ ⊢	Usual Residence of Decedent			140-	City, Town	- I contro								10	d. Inside City Limits
v апу		10a. State 10b. County N.	Δ			altin		n								XXYes 2 No
nd shov	ڃا	112				a										
Aaryland 28a-f show 1 at once	芨	10e. Street and Number						10f. Zip (10g. Citize	n of Wha	t Country	?
ith the Maryland 23a or 28a-f sho notified at once	Director	1611 Morelan	d Av	enue				212	216			14-	Ü	SA		
ith th		11. Marital Status	1 12	. Was Dec	edent Ever	in U.S.	13. Was	Deceden	t of Hispa	anic Origi	n? (Speci	ify Yes or N	lo- 1-	4. Race -	Americar	Indian, Black,
ath v items	Funeral		arried	Armed F	orces?		If Ye	s, specify	Cuban, I	Mexican,	Puerto Rio	can, etc.)		White,	etc.	
er de		3 Widowed 4 Div	orced If Y	Yes es, Give Yea	2 X	No	1	Yes 2	S No	specify:			s	pecify:	Bla	ck
36 hin 72 hours after de e. than "natural", or edical Examiner m	à	15. Decedent's Education (Spe	or	Dates:		ed) 16a. I					ind of wor	k done	16b. Kir	nd of Busi	ness/Indi	ustry
hou "nat	Completed	Elementary/Secondary (0-12)		College (1		<u> </u>	during mo	st of work	ing life. [OO NOT	use retired	1)		-		
5-0036 ed within 72 tygiene. other than '	ble	9th			, , , ,	Ma	aint	enar	ice				Mc	Dona	lds	
with with Ner t	티	17. Father's Name (First, Middle	i aet)							3.Mother's	s Name (F	irst, Middle				
filed Hyger t, the		Charles Bar		Sr.							,	aylo		ŕ		
21215-0036 buld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relations				10	n Mailing	Address				ral Route N		or Town	State, Z	ip Code)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once		Catherine Ta			dmoth		_		•							21216
두 모든 모든			YIOL	-GL ai		20b. Place of						Date		ocation - C		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		20a. Method of Disposition 1 X Burial 2 Crematio	n 3	Removal fr	rom State	cremat King I	ory or oth	er place)	- 1	Ciciy,			ŀ		•	
Page ento		4 Donation 5 Other S		_		King I	Memor	lal	Park	:	8-8-3	2007	Ran	idal	Isto	own, MD_
Baltil permit. Departm Importa injury o	- 1	21 Signature of Funeral Service		1/	Ī	-	32. N	ame and	Address	of Facility	ם ו	me W	oct	Tno	,	
Liji ji g B B		Mulmin	K.	X.	k		1/2		Jaha	ch ch	7 110	Bal	to	MD	21	215
Physician		23a Part I. Enter the disease, o	r complica	tions that o	caused the	death. Do no	ot enter th	e mode o	f dying, s	uch as ca	ardiac or r	espiratory a	rrest, shoo	k, or hear	t	Approximate Interval Between Onset and
/Medical		failure. List Shly one cause	N 4.		unshot V	Vounds										Death
examiner		Immediate Cause (Final disease or condition resulting in death)	_		a conseque						7					
		0	b.	`												
	<u>a</u>	Sequentially list conditions, if any, leading to immediate		e to (or as	a conseque	nce of):										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	U												- 1	
. / -p .;s	Xa	events resulting in death) Last		e to (or as	a conseque	ince of):										
1760, ficate be executed g physician and sthe burial - transit			d													
be ex ician urial	n/Medical	UNPENDED	LX A	MENDED	Item#	,perFH	, G870,	,8/6/0)7,WS							
Box 68760 e death certificate b the attending physi ed for use as the bu	Ĭ,	IF FEMALE: 23b. Was decedent pregnant in				f pregnancy				· · · ·				. Date of o	delivery Da	v Year
	ian	past 12 months?	- 4	1 Live	birth nant at time	e of death				Ectopic	pregnanc	су	- 10	MOHUI	Da	y Teal
atter	sic	1 Yes 2 No 9 Ur		9 Unkr		or dod.	5 Oth	ner (Spec								
O. Box 687 at the death certific d by the attending I	Physicia	Part II. Other significant cond				t not resultin	a in the u	nderlying	cause oi	ven in Pa	ert I.	23e. Die	d tobacco u	ise contrib	ute to th	e cause of death?
P.O.		Tartii. Other significant cond		n in Coung			.9 +					1 ,	res 2 ✔	No 3	Proba	bly 4 Unknown
S, P uires t n sign Id be o	Completed by			· · · ·								24a. W				psy findings available
ords, w requir	olet											au	topsy	pı	rior to cor	mpletion of cause of
eco ne law te has ge 2 s	Ĕ	<u> </u>										1 ✔ Ye	rformed? s 2 No		eath? ✓ Yes	2 No
tal Rec		25. Was case referred to medic	al						26.Place	of Death	(Check or	nly one)		- 		
ital sician s cer irecto	Be	examiner?		pital:	Inpatient	2 ER/C	Outpatient	3 D	OA (Other ₄	Nursing	Home 5	Resider	nce 6 🗸	Other: \$	Scene
Division of Vital Records, tal or Attending Physician: The law require rs after death and Directors. After this certificate has been sited in by the funeral director, page 2 should b	ဥ	1 ✓ Yes 2 No 27. Manner of Death		-			Time of I	njury 2	28c. Injur	y at Work		28d. Descrit	oe how inju	ry occurre	ed	
n of ding Ph	on o	1 Notural	nding	FOUN	e of Injury th, Day,Year) D:		UND:		1 Y	es 2 🗸	No S	Subject w	as shot			
IVISION or Attend after death Director:	ati		estigation	Aug 1,		- At home, f	7 hrs	t footon	Louis			28f Locatio	n /Street ar	nd Numbe	r or Rura	l Route Number, City
ivit lor A after Dire	ij	1	uld not be ermined			- At nome, i	aiii, suec	t, lactory	, office bi	anumy, e	2	or Town 400 Blk. V	, State)	Augnug	Raltin	nore MD
Divi Hospital or 24 hours afte Funeral Dir tely filled in	Certification:	4 Momicide			Alley											
e Hos 24 h e Fur etely		29a. Certifier 1 Certifying	Physician	: To the be	est of my kn	iowledge, de	eath occur	red at the	time, da	te and pla	ace, and d	due to the c	ause(s) and	d manner	as stated	l. cause(s)
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical	one) 2 ✓ Medical Ex	aminer: O ar	n the basis nd manner	stated.	alion and/or	irivestigat				curred at	are unie, da				
F # F 8	ğ	29b. Signature and title of certi-						290	. License	e number						h, Day, Year)
		Lin	hi		mIP				O.C.N	И.E.			Aug	ust 2, 2	007	
		30. Name and address of person		1		h (Item 23a)										
3				dical Exa		111 Per	n Stree	et, Balti	more, I	MD 212	201					
-	tate		6 200		27											
S	rere	ST. Date filed (MODAL Pay, Mai	0 400	1 12	egistrar's	10	Goa	The state of								

07-05929 Dante Bracey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		I- For State Registrar		Ce	rtificate of	Death			Reg. I		. U = 7.	
Physicia	an/	1. Decedent's Name (First, Mid-	dle,Last)					2. Date Mont	of Death	av Ye		ne of Death
ledical Exami	ner	Dante				acey		Augu	ust 2, 20	07		242 hrs
		4a. Facility Name (if not instituti Johns Hopkins Hosp	-	umber)	4	b. City, Town, or L Baltimore	ocation of D	eath		4c. County	of Death NA	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2		e of Birth (N	MM/DD/YYY	Y) 9. Birthplace Foreign	e (State or
Director		076–74–6782	1 X M 2 F	20	Yrs	Months Days	Hours	Min. 7	7-28-1	1987	Country)	N.Y.
auk		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	, Town or Locati	on					10d.	Inside City Limits
*		Md.	N A		Balti	more					1	XYes 2 No
Aaryland 28a-f show 1 at once	양	10e. Street and Number	_			10f. Zip Code			10g.	Citizen of V	Vhat Country?	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygies within 12 hours after death with the Maryland teem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Eraminer must be notified at ance	Director	520 E. 23r	d Street			21	.218				USA	
with the ns 23; pe not	eral	11. Marital Status		cedent Ever in U		s Decedent of Hisp					ce - American Ind	dian, Black,
death or iter must	Fune		Married Armed F	2 X No		es, specify Cuban,	Mexican, Fu	uerto Ricari, e	stc.)		ite, etc.	
s after ral", riner	à		ivorced If Yes, Give Ye or Dates:		1	Yes 2 XNo		ما ما الما الما	146	Specify		
hour:	eted	 Decedent's Education (Sp Elementary/Secondary (0-12 		1-4 or 5+)		t's Usual Occupationsting of working life. I			e	ob. Kind of E	Business/Industr	у
1215-0036 Id be filed within 72 fental Hygiene. narked other than '	mple	12th grade	N		l ti	nemploye	De			NΑ		
5-0036 led within 7 Hygiene. other than	ទ	17. Father's Name (First, Middl						Name (First, M	/liddle, Mai		ne)	
21218 ould be fill Mental H marked c event, t	Be	Derrick		Smit				rice			racey	
D 21 hould nd Me is ma	유	19a. Informant's Name/Relation				Address (Street						
and 2 shou ealth and N lem 27 is n traumatic		Patrice Brac 20a. Method of Disposition	ey M	other 20h.		D E. 23r		eet, B			Md. 2.	
Baltimore, MD 21215-0036 Departit Pages 1 and 2 should be filed within 72 Department of sellant and Mental Hygiene. Important: If item 2 is marked other than njury or other traumatic event, the Medical		1 Normation 2 Cremation	on 3 Removal f	from State	crematory or otl	ner place)					Hanover	
ti. Pag rtment rtant		4 Donation 5 Other 21. Signature of Funeral Service		H	eavenly	Rest lame and Address		<u>8-8-07</u>				er, N.J.
Baltir permit. F Departme Importar		M 0 and		me-		1101 E.		Marc Ave.	n F. , Bal	H. Ea	ast e, Mđ.	21202
Physician		23a. Part I. Enter the disease,	r complications that								eart App	proximate Interval
/Medical xaminer	8 9	failure. List only one cause immediate Cause (Final disease	Mandainle C	unshot Wou	nds						l be	Death
xammer		or condition resulting in death)		a consequence	of):			185				
	Ŀ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):							
	m.	cause. Enter Underlying Caus (Disease or injury that initiated	e c									
cuted CC	Exal	events resulting in death) Las		a consequence	of):							
execu an and		UNPENDED	AMENDED	20c pe	er fh ge	370 8-6-0	7 vt					
760, ficate be g physicii the buri	//Medical	IF FEMALE:		, outcome of pre-	gnancy					23d. Date	of delivery	
687 ertifica ding p	an/I	23b. Was decedent pregnant in past 12 months?	I LIVE	birth		etal death 3	Ectopic p	regnancy		Month	Day	Year
Box 687 ne death certifi the attending	Physician	1 Yes 2 No 9 U	nknown 9 Unki	nant at time of d	eath 5 01	ther (Specify)						
i, P.O. Be ires that the de signed by the	Ph	Part II. Other significant cond			resulting in the i	underlying cause gi	iven in Part	I. 23	e. Did toba	cco use cor	ntribute to the ca	ause of death?
P.O. es that to signed by be detac	d by							1	Yes	2 🗸 No	3 Probably	4 Unknown
rds, requii	Completed	9						24	a. Was an autopsy		. Were autopsy	findings available etion of cause of
eco ne law te has ge 2 s	ф							—	performe Yes 2	ed?	death? 1 ✓ Yes	2 No
Vital Rec ysician: The his certificate director, page		25. Was case referred to media	cal			26.Place	of Death (C	heck only one				
Vita lysicia this ce direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other 4 N	Nursing Home	5 Re	esidence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law requir as the deal. In Director: After this certificate has been seled in by the funeral director, page 2 should I	n: T	27. Manner of Death	28a. Dat	e of Injury th, Day,Year) D:	28b. Time of FOUND:		y at Work?	Subje	escribe hov	w injury occi	urred	
sion ttend death. ctor:	atio		estigation Aug 2,	2007	2207 hrs		es 2 ✔ N	10				
Divis pital or At ours after d eral Direc	ertification:		uld not be			et, factory, office bu	uilding, etc.	28f. Lo	Town, Stat	eet and Nur te) Baltimore	nber or Rural Ro	oute Number, City
ospita hours unera	ပ	4 V Homicide	Physician: To the be	/ Townhous			to and place					
Division of Vital Records, P.O. Box 68 To the Bospital or Attending Physician: The law requires that the death certif within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying one) 2 ✓ Medical Ex	caminer:On the basis	s of examination	and/or investiga	tion, in my opinion,	death occu	rred at the tin	ne, date an	d place, and	d due to the cau	se(s)
To wit To con	Mec	29b. Signature and title of certi	and manner	stated.		29c. License					gned (Month, D	
		(aude	Hai	lan	_	O.C.N	И.E.			August 3	, 2007	
		30. Name and address of person	on who completed ca	use of death (Ite			-					
7		Carol Allan, MD A	ssistant Medica	4		Street, Baltimo	ore, MD 2	21201				
S Regis	tate	31. Date filed (Month, Day, Yea	6 2007	egistrar's Signa	ture	ask)						
Regis	માલી	700 o	5-26	Colver 1								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 2,2007 Year **Physician** LORRAINE MARGARET BOYLE 4:01P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1702 RICH WAY APT. 2D FOREST HILL HARFORD FOREST III. B. B. Date of Birth (Month, Day, Year) 9-19-1925 6. Sex Social Security Number 213-20-1465 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 81 1 M XXF MARYLAND Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location a or 28a-f show t be notified at 10d. Inside City Limits 1 ☐ Yes 2X No MD HARFORD FOREST HILL Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1702 RICH WAY APT. 2D 21050 U.S.A. "natural", or items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 9 permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important; If Item 27 Is marked other any In]ury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM DAVIS UNKNOWN (UNKNOWN) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 5 0 19a. Informant's Name/Relationship (Type. Print) HUSBAND ELLSWORTH D. BOYLE, SR. 1702 RICH WAY APT.2D FOREST HILL, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 4 □ Donation 5 □ Other (Specify) 8-7-07 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit the death certificate be executed Exam Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by PUTHYROIDISM 1 Yes 2 No 3 Probably 4 Unknown DEMENTA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Japital o.
4 hours after de...
-vral Director: An. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA AUGUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH BEL HR 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 6 Registrar AS AS S

07-05824

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Runaiu bi	DIN		State of Marylan - For State Registrar	•	ent of Health and cate of Death	и менан пудк	ene Reg. 1	No.	7 1 03
P Medical	hysicia	an/	Decedent's Name (First, Middle,Last)				ate of Death Ionth Da Ily 30, 2007		3. Time of Death 0220 hrs
Wieulcai	LXaiiii	ilei	Ronald Bond 4a. Facility Name (if not institution, give street and numb	er)	4b. City, Town, or		ily 30, 2007	4c. County of Deat	
			Maryland General Hospital	,	Baltimore				
	uneral	Ī		Age (In yrs. last bir	rthday) If Under 1 Year Months Days		Date of Birth(N	MM/DD/YYYY) 9. Bi Forei	rthplace (State or gn Maryland
Dil	rector		216-58-1812 1 XM 2 F	53	Yrs.		09/22/1	953 °	ountry)
um Tue at escal gold state	any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
and	show nce.	ō	Maryland		Baltimore				1 X Yes 2 No
Maryl	23a or 28a-f show notified at once.	Director	10e. Street and Number		10f. Zip Code	216		Citizen of What Cou	intry?
C S	23a o notifi		2900 Forest Glen Road 11. Marital Status 12. Was Deceded	ent Ever in II S	13. Was Decedent of His			S.A.	rican Indian, Black,
leath w	r items	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Force 1 Y Yes	2 No		, Mexican, Puerto Rica		. White, etc.	W1702/11
after	ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1978	1 Yes 2 X No			Specify: Blad	
2 hours	"natu	ted	15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4		 Decedent's Usual Occupat during most of working life. 		done 16	b. Kind of Business	/Industry
036 Ithin 73	ne. r than [edica]	Completed	12	,, ,,	Nursing Assi	stant		Medical	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	dental Hygiene. narked other than "natural", or items event, the Medical Examiner must be.		17. Father's Name (First, Middle, Last)			18.Mother's Name (First Annie Sta		den Surname)	
2121	Mental I marked event,	To.Be	Roy Bond 19a. Informant's Name/Relationship (Type, Print)	19	9b. Mailing Address (Stree			r. City or Town. Stat	e. Zin Code)
MD d 2 short	F Health and Mental F Fitem 27 is marked er traumatic event, <u>t</u>		Annie Bond / Mother	2	2900 Forest G	len Road,	Baltimo	ore, Mary	land 21216
2 - S	를 를 들		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from		of Disposition (Name of cer atory or other place)		- 1	0c. Location - City o	
timo	tant:		4 Donation 5 Other Specify:		son Forest V	1 .	I .		ls, Maryland
Baltin Permit.	Department Important:		91. Signature of Funeral Gervice Licensee		22. Name and Address	of Facility The De	errick (C. Jones	F/H, P.A. yland 21215
Phy	sician		23a. Part I. Enter the disease, or complication. The caus failure. List only one cause on each line.	ed the death. Do n	not enter the mode of dying,	such às cardiac or res	piratory arrest,	shock, or heart	Approximate Interval Between Onset and
Stene	edical miner	2 2	Immediate Cause (Final disease a. Gastrointe		orrhage complica	ted by renal	insuffic	iency	Death
~			or condition resulting in death) Due to (or as a co	nsequence of):		V			
		ner	if any, leading to immediate Cause. Enter Underlying Cause	nsequence of):			·		
	.=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a co	nsequence of):					
xecuted	n and - transit		d						
60, ate be ev	lysiciar burial	Medical	IF FEMALE: AMENDED #23a,27, 23c. If yes, out	perME, g871,	9/4/07 TT			23d. Date of delive	
687(ding ph	an/N	3b. Was decedent pregnant in the past 12 months?		Petal death 3	Ectopic pregnancy		Month Month	Day Year
Box 687 e death certific	e atten	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		5 Other (Specify)				
O. Hat the	has been signed by the attending physician 2 2 should be detached for use as the burial		Part II. Dther significant conditions contributing to de	ath but not resulting	ng in the underlying cause g	iven in Part I.			the cause of death?
Division of Vital Records, P.O.	n signe Id be d	ed by							obably 4 V Unknown
cord	has bee 2 shou	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Rec	certificate ector, page		OF Man and an extension of the latest and the lates		00 Plans	of Dooth (Observed)	1 Yes 2 ₩		res 2 No
/ital	his certifi director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpa	atient 2 ER/C		of Death (Check only Other Nursing Ho		sidence 6 Othe	эг:
of of	t. After this funeral dir		27. Manner of Death 28a. Date of	njury 28b. y,Year)	Time of Injury 28c. Injur	y at Work? 28d	. Describe how	/ injury occurred	
Sion	death.	catio	1 X Natural 5 Pending 2 Accident Investigation			es 2 No			
Div.	rs after al Dire led in t	Certification:	Suicide Could not be determined (Specific)	injury - At nome, f	farm, street, factory, office b	uliding, etc. 281.	or Town, State		ural Route Number, City
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of	my knowledge, de	eath occurred at the time, da	te and place, and due	to the cause(s) and manner as sta	ited.
Wy E	within To the comple	Medical	one) 2 Medical Examiner: On the basis of e						
	(H)	Σ	29b Signature and title of certifier		29c. Licens		1	9d. Date signed <i>(M</i> i July 31, 2007	onth, Day, Year)
			30. Name and address of person who completed cause of	of death (Item 23a)	0.0.1	VI.L.		Giy 51, 2007	
0	Y		Lamn Locke MD. Assistant Medical E		1 Penn Street, Baltin	nore, MD 21201			
		ate	31. Date filed (Month, Day Year) 6 2007 32. Re	trar's Signature	Sporte				
	Regist	TELL	(100 0 0 0 0000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year July 2007 31 16:45 pM ANITA Ε. BENJAMIN-BROWN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BELAIR HARFORD CO If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 NEW YORK 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🔀 F 110-42-2457 55 FEB. 9 1952 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MARYLAND HARFORD CO BELATR 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 953 SABLEWOOD RD APT J 21014 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by Specify: BLACK 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIRECTORY ASSISTANT OPERATOR BELL ATLANTIC 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ MILTON BENJAMIN ELAINE KUAIAINA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle Gore/Daughter 1360 Harford Sq. Drive, Edgewood, Md., 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 **K**K remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 08-03-07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lice 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A.
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tepa Ence disease or condition resulting in death) Iweek Due to (or as a concequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine 709 ilni c that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Houte Fallence 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner **Funeral** Director Department of Health and Mental Hygiene. Important if items 23a or 28a-f show important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical Examiner Certification: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HOSPITALIST DOD66136 , MD 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER CHISAPEAKE DR NNENNA UCHENDU, MD BEL AIR IND Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

AUG 0 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. AMEND TTEM#29d per PHYS G870 8/6/07 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Hilda Adelaide Bichell ам 08/02/2007 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Future Care - Charles Village Baltimore N/A If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-14-0486 86 Director 08/23/1920 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at N Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4 South Gay Street 21202 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify Be Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Missionary Religious 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Bichell ဂ္ Minnie Shelhase 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is rr any injury or other traum Gunhild Carlson (Pers. Rep. 4 South Gay Street, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Yocum's Cemetery 08/07/2007 Grille, PA 1 □ □ □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. It ter the disease, or complications 1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Furneral Director; After this certificate is completely filled in by the furneral director, page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of ce

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

32, Registrar's Signatur

07-05863	
Jordan Tay	Jor Brown

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Physician/ Month Day July 31, 2007 Medical Examiner 1814 hrs 6 101 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min Directo Country) 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 No 28a-f show timore Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 122 23a death with Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status or items Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married Yes Yes 2 No specify: within 72 hours after If Yes. Give Year Specify Pages 1 and 2 should be filed within 72 hours after neut of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 'or other traumatic event, the Medical Examina. 3 Widowed 4 Divorced à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD-21215-0036 Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Maiden Surna Brown ore 9a. Informant's Name/Relationship (Type, Print 19b. Mailing Address or Rural Route Number, City or Town, tate, Zip Code) 21229 lother 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place 2 Cremation 3 Removal from State tant: timore Donation 5 Other Specify: Services Suna ure of Funeral Service License more Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. **Physician** Between Onset and /Medical Death a. Gunshot wound to the back of the neck Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated 123 Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical physician the burial -UNPENDED AMENDED The law requires that the death certificate be Box 68760 IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of s certificate has be rector, page 2 sb has performed? death? ✓ Yes Yes 2 No 2 Nο 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Jul 30, 2007 Subject was shot n 24 hours after death.

Re Funeral Director: A letely filled in by the fu 1 Natura 2300 hrs Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 600 block of Winans Way, Baltimore, MD determined (Specify) Inside of car 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within To the the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 2, 2007 30. Name and address of person who completed cause of death (item 23a) ハ 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State 6 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item, 23 pt II per md 8877, 3-25-08 t State of Maryland Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last)

Amend Items 2, 28f per ME, 8879 608 402 107 dbbth Reg. No. 07/29/2007 3. Time of Death 2. Date of Death Month **Physician** PHILIP BERNSTEIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 06 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) sol ic Beimmure Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□ F Director 578-34-9362 04/17/1930 NY Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 40 STONE PINE COURT 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mi 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 X No Specify: WHITE Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hyglene. Iem 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ PHYSICIAN MEDICAL 18. Mother's Name (First, Middle, Maiden Surname)
BEATRICE Beatrice Gutterson GUTTERMAN 17. Father's Name (First, Middle, Last) Maryland Be LOUIS BERNSTEIN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM BERNSTEIN / WIFE <u>40 STONE PINE COURT - BALTIMORE, MD 21208</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 70 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department or
Important: If i MT. LEBANON 08/01/2007 | ADELPHI, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lightse 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on such as cardiac or respiratory arrest shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subducel Messive da disease or condition resulting in death) */Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flar y leading to him addeduced as Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 24a, Was an autopsy perform 2 10 No Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 7/27/2007 15:00 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 40 Stone Pine Ct. completely filled in by 4 ☐ Homicide Residence Baltimore, MD 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) arma mella MI D29633 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smalls Wolma NO 31. Date filed (Month, Day, Year) 82. Registrar's Signature State AUG 0 2 2007 Registrar

Charles Ezekiel Coop	er	
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Charles Ezekiel C		er State of Maryland / Department of Health and Mental Hy For State Certificate of Death		. 211	17 1.991
Physician	R	edistrar . Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death		3. Time of Death
Medical Examine	"	Charles E. Cooper	Month Da August 2, 20	oy Year 07	1540 hrs
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
	H.	801 Winters Lane, Apt. 433 Catonsville		Baltimore Co	
Funeral	4,	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	_ `	MM/DD/YYYY) 9. B Fore	ign Many land
Director	I.	215-30-5231 1-M 2 F 71 Yrs. Yrs.	Sept. 21,	1935	country)
	[Isual Residence of Decedent			10d. Inside City Limits
any and any any and any any					1 Yes 2 CNo
Maryland 28a-f show d at once	₫	Md Baltimore Catonsville De Street and Number 10f. Zip Code	100	Citizen of What Co	untry?
Mar r 28a	Director	0e. Street and Number Col. L. L. L. L. L. L. L. L. L. L. L. L. L.	1.03	U-J. A	1.
with the Maryland ns 23a or 28a-f sho be notified at once		1. Marital Status 1. Was Decedent Ever in U.S. 1. Was Decedent of Hispanic Origin? (Spanish Properties of Hispanic Origin?)	pecify Yes or No-		erican Indian, Black,
ath w	கட	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	
i, or		1 Yes 2 No 3 Widowed 4 Divorced lif Yes, Give Year 1 Yes 2 No specify:		Specify: B	ack
urs af	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of visual Occupation)		b. Kind of Busines	s/Industry
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	ieu)	0 1	1.
036 rithin ene.	Completed	12 Carpenter		Constru	ction
5-00 iled wit Hygien Jother the M	ဒီြ		(First, Middle, Mai		
2121 uld be fil Mental I marked	8	The mas Cooper Kuth & 19a. Informant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number or I	fan 116 Rural Route Numbe		te. Zip Code)
O 8 5 7 €	٩		new Cast		19720
ore, MC es 1 and 2 s of Health a If item 27	H	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City	or Town, State
nore nt of h		1 Burial 2 Gremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 4 Donation 5 Other Specify:	7,2007	Balto.	led.
Baltimo permit. Page Department o Important: injury or oth	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Ficility Ca-lfon.		Service F	.4.
Ba Dep Dep		(aslph C. Dandan 1701 Mc Cullish ST	· Dano-	Md. 21	217
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease			Death
Adminer		or condition resulting in death) Due to (or as a consequence of):			
	ا ۾	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	Examine	Clicage or injury that initiated C.			4
nsit ed of for	Ξ	events resulting in death) Last Due to (or as a consequence of):			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/Medical	d. UNPENDED AMENDED			
60, ate be hysicie e burie	g 	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	ery
387 rtifica	<u>ا ۾</u>	3b. Was decedent pregnant in the lack to 2 Fetal death 3 Ectopic pregn	ancy	Month	Day Year
Box 687 e death certifice the attending p ed for use as th	Sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown			
the de	ᇍ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
P.C s that gned t	<u>اھ</u>		1 Yes	2 No 3 P	robably 4 🗹 Unknown
ds, equire een si; ould b	ompleted		24a. Was an		autopsy findings available to completion of cause of
COT law r has b	ם		autopsy	ed? death	?
Re: The	ပ	25. Was case referred to medical 26.Place of Death (Check	1 Yes 2	No 1 ✓	Tes 2 No
Sion of Vital Attending Physician: rdeath. ector: After this certifi by the funeral director,	a	examiner? Hospital: 4 Innation 2 FR/Outnation 3 DOA Other 4 Nursi		esidence 6 🗸 Ot	her: Scene
of V g Phy her th	밁	1 Ves 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
on on ath.	힐	Natural 5 Pending			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that th irs after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detach	lä	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City
Division of Vital Records, P.O. Box 6876 outsile or Attending Physician: The law requires that the death certificat ours after death. reral Director: After this certificate has been signed by the attending phinifilled in by the funeral director, page 2 should be detached for use as the	Certification:	4 Homicide determined (Specify)	Or Town, Old		
8 = = >1		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause	(s) and manner as s	tated.
To the Hos within 24 h To the Fur	Medical	and manner stated.		29d. Date signed (
	≥	29b. Signature and title of certifier O.C.M.E.		August 3, 200	
		arotracent		, _ , _ ,	
2		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212 	01		
	ate	31. Date filed (Month, Day, Year) 32, Registrar's Signature			
Registi	_	AUG 0 6 2007			
DHMH 17 Rev 1/20	01	ORIGINAL			

Phys /Me Exa

Fune Direct

1	For State Registrar		Sla	ate of Ma	ai yian				ieaith a D <i>eath</i>	and IV	lental Hy	/giene Reg. No	73 :	1117	21.99	
	. Decedent's Name	e (First, Middle				······································					2. Date of D	eath Da	- b	Year	3. Time of Death	
	HELEN	7	CIA	MBUT	ITI						AUGUS			2007	7:20 AN	
r 4	a. Facility Name (If								Location of			40		y of Death	1	
	JOHNS HO		· · ·					er 1 Year	If Under		O Data of D	-11-	N/Z		(0)	
5	. Social Security No.		6. Sex 1 ☐ M 2		9 2	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D	ay, Year		Cot	nplace (State or Foreig untry)	
l	Isual Residence of				92			1			July1	8,1	915	Pa	1	
	0a. State	10b. County			10c. Cit	y, Town or Lo									10d. Inside City Limit	
<u>.</u>	Md. Baltimore Dundalk											1 □ Yes 2X No				
1	0e. Street and Nur	^{nber} altim	oro A	WO			10f. Z	ip Code	21	222		10g. Ci		What Cou	untry?	
<u> </u>		artim			Cura la II	6 40 1	Man Dan	adamt of L			oit. Van av N		USA		ican Indian	
	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am Black, Wh															
2	3 ₩ Widowed		If Ye	∏Yes 2[X 1 Yes, Give ear or Dates:	***		1 ☐ Yes	2 <mark>∑</mark> No	Specify:				Speci	fy:	White	
neredilloo ed	/Cnac		nt's Education			16a. Dece			ation during mos	t of work	ina	16b. F	Cind of E	Business/I	ndustry	
1	Elementary/Seco	ify only highe ndary (0-12)		ollege (1-4or 5	5+)	life.	DO NOT	use retired	1)	i or worki	ng					
5	8 yrs	-					Но	usew						ome		
	7. Father's Name (ine Gi			me)		
2 -						10b Mailir	na Addroi	ns /Stract			al Route Num			Cto to 7	in Code)	
	19a. Informant's Na Patri				ught			•			ve. Di				21222	
2	Oa. Method of Disp				20b. F	Place of Dispo	sition (N	ame of							Town, State	
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Cemetery, crematory or other place 20c. Location - City of Cemetery, crematory or other place 20c. Location - City of Cemetery, crematory or other place 20c. Location - City of Cemetery, crematory or other place 20c. Location - City of Cemetery, crematory or other place 20c. Location - City of Cemetery, crematory or other place 20c. Location - City of Cemetery, crematory or other place 20c. Location -										more	е				
-	21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222															
	26	his.	mil	SK L	7	9	Jonn 1110	elly	Fun	era	Home	Of	1 Di	inda:	lk	
+	23a. Panil. Enter ti	he disease, or	r complication	ns that crused	the deat	h. Do not ent	ter the me	ode of dyir	ng, such as	cardiac	or respiratory	arrest,			Approximate Interval Between	
	23a. Part. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition PULMOVARY EDEMA												Onset and Death			
	resulting in death) Due to (or as a consequence of):											, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Sequentially list conditions, b. ACUTE MYOCARDIAL INFARCTION											1 WEEK				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury															
= 1	Cause (Disease or injury that initiated events c.															
3	resulting in death) Last Due to (or as a consequence of):															
	d															
	F FEMALE: 23b. Was deceden	t progrant		yes, outcome									23d. D	ate of deli	te of delivery onth Day Year	
5 '	in the past 12 1 Yes 2	months?		□Live birth □Pregnant a			⊒Ectopic ⊒Other (pregnancy specify)	/					lonth		
-	9 ☐ Unknown	₹2 IAO	9	Unknown												
F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con									ntribute to	the cause of death?					
- 2	1 ☐ Yes 2 1 No 3 ☐ I										3∏ Pr	obably 4 □Unknow				
											24a. Wa		24b	. Were au	topsy findings availab completion of cause of	
5											per	opsy formed? 2 N		death?	_	
	25. Was case refer	red to medica	ıi						26. Place	of Deatl	n (Check only					
	examiner? 1 ☐ Yes 2 😿	No	Hospit	al: 1 dinpatie	ent 2	ER/Outpatier	nt 3∏ [OOA Oth	er: 4□ Nu	ırsing Ho	me 5□Res	sidence	6 □0	ther (Spec	cify)	
į [²	27. Manner of Deat	h 5 ☐ Pendir		a. Date of Inju (Month, Da		28b. Time o Injury		28c. Injur Wor	k?		28d. Describe	how inju	ary occu	ırred		
3	2 ☐ Accident 3 ☐ Suicide		igation				М		Yes 2□							
	4 ☐ Homicide	detern		e. Place of inj building, et	ury - At h c. <i>(Specil</i>	ome, farm, str fy)	reet, facto	ory, office			28f. Location City or To	(Street a	nd Nun te)	nber or Ru	ıral Route Number,	
3	20a Codifia	1 None	na Physicia	r To the best	of my len	wiledge door	th occur	ad at the At	me detec	nd place	and due to di	0.00::=:	0) 02-1	non====	ototod	
2	29a. Certifier (Check only one)	2 Medical	Examiner: (i: To the best On the basis o and manner st	f examina	wieuge, deat ation and/or in	vestigati	on, in my	ppinion, dea	ath occur	and due to th red at the time	e, date a	o) and r nd place	nanner as e, and due	stated. to the cause(s)	
		title of certifie		a manifer St			2	9c. Licens	e number			29d. D	ate sign	ed (Montl	h, Day, Year)	
										00					1,2007	
ME		P M														
	30. Name and addr					n 23a) (Tyne	Print)									

			State of Maryland / Department of Health and State of Maryland / Department of Health American / Department of Health / Department of Health / Department of Health / Department	d Mental Hygiene Reg. No 2007 24992
	Physicia "/Medic	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Jocation of Decederation of Deced	2. Date of Death Month Day Year JULY 21, 2007 0730 M
	Funeral Director		Currol Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15. Months Days Hours N Usual Residence of Decedent	Hrs. 8. Date of Birth Gountry Feb. 25, 924 Mary and
4.0	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Health and Mental Hygiene. Tar Is marked other than "natural", or items 23a or 28a-f show defect traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location Battmore 10c. Street and Number 10f. Zip Code 21 21 7 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married Married Married Married Never Marri	10d. Inside City Limits 1 SYes 2 □ No 10g. Citizen of What Country? 2 (Specify Yes or Nouerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
nd 21215-0036	2 should be filed within 72 hours at and Mental Hygiens is marked other than "natural", or aumatic event, the Medical Exam	Be Completed by	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) If Yes, Give Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b. Kind of Business/Industry Federal Governmen Name (First, Middle, Maiden Surname)
Baltimore, Maryland	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic e once.	ToE	19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number of Disposition 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility	r Rural Route Number, City or Town, State, Zip Code) Le Balto, Md. 21217 Date 20c. Location - City or Town, State 26/2007 Balto Md. Funeral Home, P. A.
8760,	Physician /Medical Examiner	dical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heartfullure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last	Ceri Carcinola di
P.O. Box 68	the death certifica y the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
I Records, P	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
Division or Vital Records,	To the Hospital or Attending Physician: The lav Within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be C	examiner? Hospital: Other:	Death (Check only one) ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending It within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Ce	29a. Certifier (Check only one) 1	
,	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Saiont 2, m. p. 555 S. Center St. W. 31. Date filed (Month, Day, Year) AUG 0 2 2007	• •

DHMH 17 Rev 1/2001

07-05945 Bridgette Eppes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

idgette Eppes		State of Maryland / Department of Health and Men Certificate of Death	ntal Hygie	ene Reg. 1		7 24993
Physicia edical Examin	n/	1. Decedent's Name (First, Middle,Last) BRIDGETTE EPPES		Pate of Death Month Da Jugust 1, 20		3. Time of Death 2207 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center 4b. City, Town, or Location of Baltimore	n of Death		4c. County of Deat	
Funeral Director		5. Social Security Number 2 1 3 8 4 3 4 1 8	ırs Min.		MM/DD/YYYY) 9. Bi Forei 26,1961 ^{Ci}	irthplace (State or ign ountry) MD.
daryland 28a-f show any 1 at once.	jor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE				10d. Inside City Limits 1 X Yes 2 No
the h	ral Director	10e. Street and Number 10f. Zip Code 4918 GUNTHER AVE APT.B 21206 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori		Yes or No-		untry?
r death	by Funeral	Armed Forces? If Yes, specify Cuban, Mexican Armed Forces? If Yes, specify Cuban, Mexican Yes No No No No No No No No No No	fy:		Specify: BL	
C4 3 🔲	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) DAY CARE PROVII	T use retired) DER		SELF EM	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	(ier's Name (Firs RGARE' umber or Rural	THOM	IPSON	te, Zip Code)
re, MD 21 s I and 2 should f Health and Me If item 27 is ma er traumatic ex		MARGARET THOMPSON/mother 4838 TRUESDAY 20a. Method of Disposition 1	LE AVI	ite 2	206 BALT 20c. Location - City o	O , MD . or Town, State
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is n injury or other traumatic		4 Donation 5 Other Specify: GARRISON FOREST VI		FUNER	AL HOME	
Physician /Medical xaminer	iner	23a. Part I. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as a failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	s cardiac or res	piratory arrest,	, shock, or heart	Approximate Interval Between Onset and Death
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be be	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	opic pregnancy		23d. Date of delive Month	pery Day Year
s, P.O. B ires that the d signed by the	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I.	1 Yes	2 V No 3 Pr	to the cause of death?
Records, The law requir cate has been a	Completed			24a. Was an autopsy performe 1 Yes 2	prior to ed? death?	
n of Vital I ling Physician: After this certiff funeral director,	To Be	25. Was case referred to medical examiner? 1 Ves 2 No	Nursing Hoork? 280	ome 5 Re	esidence 6 Oth	ner:
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: A completely filled in by the fu	Certification:	Accident Suicide Could not be determined Specify Homicide Specify Spec		f. Location (Str or Town, Stat		Rural Route Number, City
To the Hosp within 24 hc To the Fun completely I	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated. 29b. Signature and title of certifier	occurred at the	e time, date an	s) and manner as st id place, and due to 29d. Date signed (A	the cause(s)
		30. Name and address of person who completed cause of death (Item 23a)			August 4, 2007	
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimor 31. Date filed (Month, Day, Year) 2007 \$2. Registrar's Signature	ore, MD 212	201	· · · · · · · · · · · · · · · · · · ·	
Regist	rar	AUG 0 0 2001 Julian July July July July July July July July				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6398 Beechfield Ave. Howard Elkridge If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/22/1925 Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days 354-16-6400 1 □ M 2 🔽 F 81 Illinois Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural', or items 23a or 28a-f show dical Examiner must be notified at MD Howard Elkridge 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6398 Beechfield Ave. 21075 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 Nidowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 Is marked other if any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elise Evensen Frederick Helmick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Candace Funk/Daughter 6398 Beechfield Ave., Elkridge, MD 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 8/6/2007 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home at MP, 7250 Washington Blvd., Elkridge, MD 21075 23a. art1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical e to (or as a con MOHON Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (or as a consequence of): death certificate be executed use as the burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown pinous Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has birector, page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 21X No 2 ER/Outpatient 3 DOA ို 1 | Inpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month

ROM

29b. Signatu



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOND'IZ.

29c. License number

non Novah Druve Columbia

29d. Date signed (Month, Day, Year,

Amend #5,18,per HD, 9870, 8/23/0/ The Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Clyde G. Fentress Month Day Year /Medical 2007 7:25a August 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 945 Sunset Valley Drive Sykesville Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1**X** M 2□ F Yrs. Director 4225-12-7567 87 Mar 28, 1920 VA Usual Residence of Decedent 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Howard 1 ☐ Yes 2√☐ No Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 945 Sunset Valley Drive 21784 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: White 34 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withi ealth and Mental Hygiene. n 27 is marked other than Manager Southern States 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archie Lilleton Fentress Mary Jo Tavenner Roxie Etta White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Mr. Keith T. Fentress (Son) 945 Sunset Valley Dr., Sykesville, MD 21784 permit. Pages : Department of He important: If Iter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Riverside mem. Park 4 Donation 5 Other (Specify) 8/10/2007 Norfolk, VA 21. Signature of Funeral Service Licensee HATCHTO FUNERAL HOME & CHAPEL, PA (Box 195) HELLER MO0764 Sykesville, MD 21784 (410) - 795 - 140023a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 HVUPS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to finine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physician and as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy þ in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) Month Day Year 1 ☐ Yes 2 ☐ No be detached the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy perform this certificate 1∐ Yes 2 1 N Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 | Yes 2 | 1 | Yo 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient s after death, il Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Iniury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 645 31. Date filed (Month, Day, Year. 32. Registrar's Signature State Registrar DHWH 17 Rev 1/2001

07-05923 Robert Felhaue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Felhauer		St - For State Registrar	ate of Maryla		rtment of tificate of		nd Mental		2) eg. No.	17 2495
Physician Medical Examin	n/	1. Decedent's Name (First, Midd Robert	le,Last)		Feli	hauer	Name of	2. Date of Dea Month August 2,	th Day Year	3. Time of Death 2000 hrs
		4a. Facility Name (if not institution Johns Hopkins Hospi		mber)	4	b. City, Town, c Baltimore	or Location of De	eath	4c. County of Dea	eth
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye Months Da		Hrs. 8. Date of Bi		Birthplace (State or eign Country)
w any		Usual Residence of Decedent 10a. State 10b. County			Town or Locati			1// 60 /	2,1952.1.	10d. Inside City Limits
ne Maryland or 28a-f show fied at once.	Director	Maryard 10e. Street and Number 3 f 2 l M f	. Pleas	- BA	H)MC	10f. Zip Code		,	i 0g. Citizen of What Co	
hours after death with the Maryland "natural", or items 23a or 28a-f she Examirer must be notified at once	— L	11. Mantal Status 1 Never Married 2 X M	12. Was Dec	edent Ever in U.S		s Decedent of H		(Specify Yes or No erto Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,
nours after d	ᇍ	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:	ar "	16a. Deceden		lo specify: ation (Give kind e. DO NOT use		Specify: U	Uhite s/industry
5-0036 iled within 72 h Hygiene 1 other than "r the Medi at E	Completed	Elementary/Secondary (0-12)		i-4 or 5+)		,	orker		Beth Maiden Surname)	Steel
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene 27 is marked other than matic event, the Meditan	8	KAT 19a, Informant's Name/Relations	F	elhan	19b. Mailing	Address (Stre	BAC eet and Number	BACA or Rural Route Nu	mber, City or Town, Sta	Sbrc cht ate, Zip Code)
MD and 2 sho ealth and em 27 is raumati		PoroHica F 20a. Method of Disposition 1 XBurial 2 Cremation	r 3 Removal fr	om State C	342 Place of Dispos rematory or oth	tion (Name of c	emetery,	75ANt	bue Ball 20c. Location - City	or Town, State
Baltimore bermit. Pages 1 & Department of Hd Important: If it njury or other t		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	Bc	(411 H	ame and Addre	Ss of Facility	Jug 7,2007	BUNERAL	- MANYLAND
Physician /Medical		23a. Part I. Entertine disease, or failure. List only one cause Immediate Cause (Final disease	on each line.	aused the death.	Do not enter th	ne mode of dying	CONJUIN	Corre	1 40/4/60 /	Approximate Interval Between Onset and Death
xaminer	<u>.</u>	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence of						
ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of						
0, be executed sician and ourial - transit	edical	UNPENDED	a. AMENDED							
6876(certificate nding phys	ŽΙ	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	the 1 Live b	nant at time of dea	2 Fe	tal death 3 ner (Specify)	Ectopic pre	egnancy	23d. Date of deliv Month	ery Day Year
P.O.	2	Part II. Other significant condi		o death but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Division of Vital Records, P.O. Box ral or Attending Physician: The law requires that the death is after death. "al Director: After this certificate has been signed by the attered in by the funeral director, page 2 should be detached for users.	Completed								psy prior to ormed? death	autopsy findings available o completion of cause of ? Yes 2 No
Vital F hysician: This certification of the director, p	o Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		Other N	eck only one) ursing Home 5	Residence 6 Ot	her:
Sion of Attending P death. ctor: After by the funera	ation: T		28a. Date (Month estigation	of Injury n, Day,Year)	28b. Time of I		jury at Work? Yes 2 No		how injury occurred	
bou hou	Certification:	4 Homicide dete	ermined (Specify)					or Town,	State)	Rural Route Number, City
To the II. within 24 To the Force Completed	Medical	(Check only one) 2 Medical Exa	aminer: On the basis and manner s	of examination ar		ion, in my opinio	on, death occurr		ise(s) and manner as s e and place, and due to	
	Σ	29b. Signature and title of certifi Aftena Bras	sell, MZ	·			nse number C.M.E.		29d. Date signed (I	,
6 1		30. Name and address of person Melissa Brassell, MD	Assistant Me	edical Examin	er 111 F	enn Street,	Baltimore, I	MD 21201		
Sta	_	31. Date filed (Month, Day Year)	6 2007 32. R	egi trar's Signatu	re 🖊 🔏					

DHMH 17 Rev 1/2001

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07-05765

7-05765		Please Type or Print in Black Indelible Ink. Ensure All Copie		ble.	
ichard B. Glad		Bey State of Maryland / Department of Health and Mental H 1- For State Certificate of Death		200	7 21,99
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death	No.	3. Time of Death
ا Filysica Nedical Exami		RICHARD B. GLADDEN-BEY		ay Year 7	0845 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		2818 S. Edgecombe Circle Baltimore	<u>-</u>	N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr. Months Days Hours Mir			thplace (State or MARYLAND untry)
Director		218-60-4593 1X M 2 F 52 Yrs.	03/01/1	955 ^{Co}	untry)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* .		KENTUCKY N/A FT. CAMPBELL			1 Yes 2 X No
Aaryland 28a-f show 1 at once,	Director	10e. Street and Number 10f. Zip Code	. 10g.	Citizen of What Cour	ntry?
death with the Maryland or items 23a or 28a-f sho	ä	8416 PARKER DRIVE 42223		U.S.A.	
with the ms 23a be noti	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S			can Indian, Black,
or ite	Funeral	1 Yes 2 X No	J Kicali, etc./	Specify: BLAC	עי
s after rral",	by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work doco	Specify: DIAC	
2 hours	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		ob. Kind of Busiliess/	ndosi y
336 thin 7, than than edical	Completed	12th grade DISABLED	10.00	N/A	
5-00 led wii tygier other the M	S		e (First, Middle, Mai	,	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	a		NE CARTER		
D 2 should and M 7 is m	٩	19a. Informant's Name/Relationship (Type, Print) Michael A. Godsey/Brother 19b. Mailing Address (Street and Number or 8416 Parker Drive, 19b.)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Michael A. Godsey/Brother 8416 Parker Drive, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place)			
it. Partment ortan		4 Donation 5 Other Specify: KING MEMORIAL PARK 08 21. Signature of Funeral Service Licensee WILLIAM C BROWN C	-07-07	BALTIMORE	E, MARYLAND
Dep Dep Ba		Darbara Chiown 1206 W NORTH AVEN	OMMUNITY . UE	FUNERAL HO	ME P.A.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac fallure. List only one cause on each line.	or respiratory arrest.	, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1 19	Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease			Death
		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in (death) last Due to (or as a consequence of):			
nted d ansit		events resulting in death) Last Due to (or as a consequence or): d.			
executed ian and ial - transit	lical	X UNPENDED AMENDED, perME, g871, 9/4/07 TT			
Box 68760, e death certificate be ex the attending physician ed for use as the burial	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	у
687 certific	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specific)	nancy	Month I	Day Year
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s, P.O. nires that the signed by d be detach	d by		1 Yes	2 No 3 Pro	oably 4 🗹 Unknown
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Reco	E O		performe 1 ✓ Yes 2		es 2 No
tal Reco cian: The law certificate has ector, page 2 s	Bec	25. Was case referred to medical examiner?			
Division of Vital Records, tal or Attending Physician: The law requin 15 after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	은	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nurs	ing Home 5 Re	esidence 6 🗸 Othe	r; Scene
n of ding Ph	on:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending	20d. Describe nov	wingary occurred	
isio Atter Atter rector by th	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stre	eet and Number or Ru	ural Route Number, City
Division spital or Attem hours after death meral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, Stat		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an			
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date an	d place, and due to th	e cause(s)
F # F 5	Ĕ	29b. Signature and title of certifier 29c. License number	ΛE I	29d. Date signed (Mo	nth, Day, Year)
9		Theodore M. King Thy, up, O.C.M.E.	,	July 28, 2007	
0 7		30. Name and address of person who completed cause of deth (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	re MD 21201		
	tate	31. Date filed (Month, Day Year) 32. Pegistrar's Signature	10, MD 21201		
Regis		31. Date filed (Month, Day, Year) AUG 0 6 2007			

			1 - State of Man		artment of rtificate of		Re	g. No.C. J.J.	24998
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Marion Naomi Hollman				2. Date of Death Month 08/03/20	Day Year	3. Time of Death 8:40 a
)	Examir		4a. Facility Name (If not institution, give street and number) 439 Rogers Ave		4b. City, Town, Glen Bu	or Location of Death		4c. County of Death	1
T	Funeral Director		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday) 77 Yrs.		If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
in in in the	yland sow at			Dc. City, Town or Lo	cation		07/26/19	30	VA 10d. Inside City Limits
	the Mar 28a-f sh notified	rector	MD Anne Arundel G	len Burnie	e 10f. Zip Code		10	g. Citizen of What Cou	1 ☐ Yes 2 No
	sath with s 23a or nust be	Funeral Director	439 Rogers Ave.		21060	···	US	SA	
5-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. "Hygiene" was 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	l I	Was Decedent of f Yes, specify Cul	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0	within 72 ho ene. than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2	(Give life. L		during most of worked)	king	6b. Kind of Business/I	ndustry
nd 2	be filed y tal Hygie d other i	Be	17. Father's Name (First, Middle, Last)	Lab Te	echnicia	18. Mother's Nam	ne (First, Middle, Ma	levamar aiden Surname)	
Maryland	2 should be and Mental is marked of aumatic eve	오	Luther Neely 19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Stree	Catherin		City or Town, State, Zi	p Code)
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		William B. Hollman / Husband 20a Method of Disposition	439 Ro	ogers Av	e., Glen	Burnie, M	D 21060	
Baltimore,			LADUNAI 2 LICIENIALION 3 LINEMOVALIONI SLALE	20b. Place of Dispos cemetery, crem eadowridge N				oc. Location - City or T kridge, MD	
Balt	permit. Page Department of Important; If any injury or once.		21. Signature of Tuneral Service Licensee	22	Name and Addre	ess of Facility		e at MMP, idge, MD 2	
	hysician /Medical		23a. Part Lenter the disease, or complications that caused the shock, or heart failure. List only one pause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition)	death. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	ysicia	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a conditional						
מֿ לַ	e attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliv	ery Day Year
ecords, P.O	been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but no	t resulting in the und	derlying cause giv	en in Part I.		cco use contribute to t	
r a	ate has	Completed					24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
r VITAI	After this certificate ha	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA Oth		h (Check only one)	ce 6 □Other (Specia	60
SION OF	within 24 hours after death. To the Funeral Director: After this certification of the funeral director, it is completely filled in by the funeral director, it is considered to the funeral director, it is considered to the funeral director, it is considered to the funeral director, it is considered to the funeral director, it is considered to the funeral director.	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				28d. Describe how		,,
	ral Direct Indiana		4 ☐ Homicide determined 25e. Place of Injury - building, etc. (S	pecify)			City or Town, S	•	
the Hoen	the Fune	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my one) 1 ☐ Medical Examiner: On the basis of examiner and manner stated.	/ knowledge, death mination and/or inve	estigation, in my	opinion, death occur	and due to the cau red at the time, date	se(s) and manner as s a and place, and due t	stated. o the cause(s)
	with Cor	2	29b. Signature and title of certifier M. D.		D5 C	e number	29d	Date signed (Month,	
5	1		30. Name and address of person who completed cause of death S. JASS, 1600 CRAIN Hw)	Suite 6	10 6	len Bur	nie, mi	021061	
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 6 2007 32. Pegistrar's 8	Signature And	ule				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05903 State of Maryland / Department of Health and Mental Hygiene Olivia Viria Harris 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 's Name (First, Middle,Last) Physician/ 0815 hrs Medical Examiner August 2, 2007 4c. County of Death 4b. City. Town, or Location of Death acility Name (if not institution, give street and numb Gwynn Oak 1905 Forest Park Avenue, Apt. S-1 If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) 58 50-М 2 / F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland death and Mental Hygiene. "natural", or items 23a or 28a-f sho Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 20 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 2 Never Married Yes 4 Divorced If Yes, Give Year Yes 2 No specify: Specify: "natural", ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than 'atic event, the Medical 1th ider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 110 20b. Place of Disposition (Name of cemetery, Date . Method of Disposition Itimore, crematory or other place) Burial 2 Cremation 3 Removal from State Pages 1 -8-2007 Donation 5 Other Specify 'n Signature of Funeral Service Licensee aughn C. Greene Funeral Services hter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock **Physician** failure. List only one cause on each line. Between Onset and Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last physician and the burial - transit hysician/Medical AMENDED UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death detached for use 5 Other (Specify) Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. signed be detail þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has death? 2 No page Yes 2 V No Yes 1 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other₄ Hospital: examiner? Nursing Home 5 Residence 6 ✔ Other: Scene 2 Inpatient ER/Outpatient 3 After this 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification Division 1 V Natural Yes 2 No Pending death. the Director: Investigation Accident within 24 hours after d To the Funeral Direct completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME August 2, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month, Pax 32. Registrar's Signature State 6 DE POSSON Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a, State of Maryland / Department of Health and Mental Hygiene regge 10,08/02/07dhb Reg. No. For A State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8 077 E William R. Hilbert 2057 Jul 9 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hes Dital Baltimory non If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 M 2 □ F Sept 7, 87 218-05-6124 1919 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1√Yes 2 No MD Director Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number be r 21207 USA 6438 Gilmore Street permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a any injury or other traumatic event, the Medical Examiner must I Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2X Married white 1 ☐ Yes 2X No Specify. Specify. Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 mechanic Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hilbert Ruth Hepliner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4529 Ambermill Road Nottingham, MD 21236 Rick Hilbert/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State July 23, 2007 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Baltimroe, MD 21. Signature of Fundal Signature Licensee Ronald Signature 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician intracramia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit Control to Mappione El Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 | Yes 2 | No 3 | Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autonsy performe 2.0 No After this certification funeral director, I 25. Was case referred to medica examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes -2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury
Found
Unknown 28a. Date of Injury Found, Day Year) 06/24/2007 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Probable fall. 1 ☐ Yes 2X No death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6438 Gilmore St. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home Baltimore, MD

P.O. Box 68760, Division or Vital Records, or Attending Physician: Hospital

3altimore, Maryland 21215-0036

4:1 bert

within 24 hours after death

To the Funeral Director;
completely filled in by the f

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

XIONG

and manner stated.

MD

1-2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year)

29c. License number